

Healthy Alaskans 2010

Targets and Strategies for Improved Health

Volume II: Creating Healthy Communities An Alaskan Talking Circle

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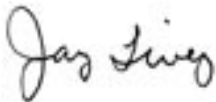
Dear Alaskans:

On behalf of the Alaska Department of Health and Social Services, we are pleased to present *Creating Healthy Communities: An Alaskan Talking Circle*, a plan which gives insight into how Alaskans from rural and urban communities, Native organizations, state and federal agencies, and private businesses and organizations can put traditional and new knowledge together to reach the goals for improved health. Together with the information on many targets in Volume I, the strategies described here may encourage and inspire solutions to problems that affect health and well-being.

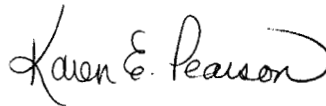
The Alaska Division of Public Health will use the Healthy Alaskans 2010 process to monitor changes in the health status of Alaskans over the next 10 years. Healthy Alaskans 2010 serves as a framework for health policy development, identifies the best indicators of health status, sets ambitious but achievable targets, and shares information with all partners. We will also continue to facilitate the sharing of effective local and statewide programs and strategies. We encourage schools and communities to carry forward the approach used in this book, to share good ideas and to discover approaches that are culturally relevant and effective.

We encourage you to use this plan and work with us to improve the health of all Alaskans by the year 2010. Together we can achieve our goals of eliminating health disparities and ensuring that all Alaskans have access to quality care.

Sincerely,



Jay Livey
Commissioner



Karen Pearson
Director of Public Health

ACKNOWLEDGMENTS

The Healthy Alaskans Partnership Council, as the Healthy Alaskans 2010 process advisory group representing people and organizations from across the state, asked the Division of Public Health to find a new approach to strategic health planning. They approved the idea of using stories about local efforts to improve community health to provide strategies to help other communities. Staff members Nick Coti, Margo Waring, Susan Keady and Christopher Wright talked with dozens of people, in dozens of communities, about their work, communities and families, to explore lessons learned and outcomes. Many advisory group members provided encouragement through their enthusiasm and excitement for the story project. This made the project even better.

Individuals in many communities around the state have given generously of their time, their caring, and their thinking about how they became involved in making their community and its people healthier and happier. In addition to the folks described in the various stories, many others including public health nurses, community health aides and practitioners, students, and other citizens of many ages have provided nuggets for these and other stories to be written. We have discovered rich diversity in traditions that can be drawn upon, positive attitudes toward “new knowledge,” and many examples of effective partnerships and collaborations between local, state, and federal entities, including individuals, government agencies, businesses and non-profit organizations. Sharing the experiences, strategies and knowledge among communities and neighborhoods will help all Alaskans reach the targets for improved health for 2010 and beyond.

Many of the contributors to this project are directly quoted in the various chapters. Others are not, out of respect for the wishes of contributors regarding publication of their names. However all of the individuals who shared their insights and experiences, whether they are cited or not, have made this a better publication. Their contributions are appreciated. These are gifts we seek to give again to others. Sharing knowledge is a central theme of this effort.

Health and Social Services Commissioner Jay Livey provided unwavering support for this effort, together with Karen Pearson, Director of the Division of Public Health, and Janet Clarke, Director of the Division of Administrative Services, who co-chair the Healthy Alaskans Partnership Council. They confidently supported the staff’s efforts to discover and present the inspiring stories and concepts that have strengthened Alaskan communities.

Jim Craig and Julie Sanbei designed the publication. Original drawings and graphics are by Julie Sanbei, unless noted otherwise. Special thanks to the artists and authors who have given permission (as noted through the book) for photos, replications and quotations. The cover photograph taken by Margo Waring is “An Eagle/Raven Memorial to Kake Elders.” The work was commissioned by and is the property of the Kake Tribal Heritage Foundation, carved by Mike and Norman Jackson, and dedicated September 25, 1994. Nick Coti took the photographs of the Bethel dumpsters.

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INTRODUCTION

THE STORY OF THE STORY PROJECT

The story concept for Volume II of Healthy Alaskans 2010 developed in an evolutionary way from early discussions between the Department of Health and Social Services and the Healthy Alaskans Partnership Council. We were asked to devise a strategic plan that addressed the whole state and not just the activities of our department.

In the spring of 2001 the Healthy Alaskans Partnership Council agreed to be our advisory body for this project. In an exercise that envisioned the talking circle principle that organizes this volume we went around the room a couple of times to get the guidance, ideas and perspectives of each Council member. Through this exercise we formulated the *10 Core Principles* that have guided this project.

We built *Volume I: Targets and Strategies for Improved Health* around the monitoring of indicators for the decade, following the approach of the federal Healthy People 2010 plan for the nation. For the second volume, the strategic plan, we began talking about communities or neighborhoods that for reasons of ethnic or geographic isolation were usually marginalized in planning processes. The communities were often left out of statewide examinations of issues or their issues were not acknowledged.

It was really the looks on the Council members' faces more than what they said out loud that directed this project. Seeing them yawning and their eyes glazing over when you started talking about a strategic plan in the usual planning jargon led me out of desperation to start using anecdotes.

I told the Council about a recent experience—we had given a workshop in Sitka to Community Wellness Associates from around the State. At the end of the workshop we asked them if there were any other issues or questions on their minds. An Associate from one of the smallest communities asked for some training in how to do peer counseling better in her community. She said in a quiet voice that they had been trying it and it seemed to be “too burdensome, too much for our kids. They all know each other very well; we’re related. My son was very upset when he was asked to do peer counseling with one of his classmates. It really upset him to hear about abuse and drug problems. He did not know how to handle it.”

We said we didn’t know what was right for them, but suggested that peer counseling may not be the appropriate model for her small community. We urged her to talk with the other Community Wellness Associates to see what their experiences were. It seemed that more damage might occur in her community with this particular model even if it is considered a “best practice.” Trying to use it might make good people feel like failures. We suggested consideration of adult mentoring or healing circle approaches. As we were to learn clearly from stories we would collect for this volume, well-intentioned, imported “best practices” may not fit. Local control in selecting or designing a strategy is essential.

The Council felt that this was exactly what we needed in the plan: real examples, diverse approaches and the use of stories to convey the complexity and richness of detail. They asked us to limit the “didactic” material to commentary or links to other material, and relegate the summary of existing plans to a third volume.

Since then we have had only positive responses as we have moved toward story telling. And then we started to uncover stories! We believe this effort puts the “equal sign” between strategic planning and stories directly, in a way we have not seen elsewhere. I think this is a positive contribution.

-Alice Rarig, Chief
Data and Evaluation Unit

PUTTING THE PLAN TOGETHER

The task outlined by the Department and the Council was clear enough. Through stories, the strategic plan should address the importance, richness and complexity of the historical, cultural and geographical diversity of Alaska and its health challenges. The health problems and their solutions should reflect the variety in size and structure of Alaskan communities.

The plan should recognize and honor the role and good work of the people at the program and community level who often appear only as abstractions in statewide strategic plans, yet who grapple with the difficult problems on a daily basis. The stories should be written in a clear, interesting and friendly manner. They should be accessible to people in smaller communities of diverse cultural and language backgrounds. Finally, the plan also needed to address all the issues in the twenty-six chapters of Volume I. But it should not be organized in the same format as Volume I—although it should be cross-referenced in such a way that it was easy to find the connections. And, by the way, it should be short.

The practical solution to this challenge came when I attended a talking circle of elders and youth at the Alaska Conference on the Environment in January, 2002. The elders were from all over the state: Yup'ik, Inupiaq, Athabascan, Aleut as well as Non Natives who had made life long commitments and contributions to Alaska. The youth in the circle included Athabascan kids from Chickaloon and Caucasian kids from Anchorage. The subject of the circle was the environment. The purpose was to teach, to encourage understanding, critical thought and problem solving. The first day was spent listening to elders telling stories about the environment. The youth were then asked to create their own stories about the environment for presentation the following day.

It quickly became clear that the talking circle was the format that we sought for the strategic health planning volume of Healthy Alaskans 2010. Stories are a traditional teaching tool of the circle. The circle's rules encouraged participants to be good listeners and honest speakers, to learn, to teach, to appreciate complexity, context, sadness, humor, insight and the validity of diverse points of view. The format and procedures of the circle are respectful and egalitarian. The circle may have many or few participants and could adjust to any size.

The talking circle concept highlighted the importance of the *voice* of the storyteller. So retaining the voice of the community and of the individuals who owned the problems, experience and the solutions was essential. In some cases we were fortunate to have members of the community itself tell the whole story. In other cases we were tasked with providing the “story shell” and illuminating it with the words and insights of the participants. In many cases, numerous rounds of participant reviews followed taped interviews. The most rewarding part of the story project has been learning how to get out of the way and let the story and the storytellers enrich our understanding.

When all is said and done, the plan that you have in your hands is not a talking circle, no matter how much we wish it were. Our goal during this project has been to promote a talking circle among communities and neighborhoods to enable Alaskans to share their experiences making our communities healthier and happy places. This plan comes closer to a real talking circle when you read, consider, share, expand, and retell these stories and add new ones.

-Nick Coti, Planner
Data and Evaluation Unit

TIPS FOR USING VOLUME II

Creating Healthy Communities: An Alaskan Talking Circle emphasizes the importance of Alaskans sharing insights and experience as we work toward making healthier, happier, and safer lives for ourselves as individuals, communities and a state. Designed to help the strategic efforts in communities and neighborhoods, this volume should be useful to a wide range of Alaskans: elders and legislators, policy makers and health care practitioners, administrators and students, grant writers and community activists, to mention a few.

There are fourteen chapters in this volume. As you move through the chapters, the story settings tend to change from Alaska's smaller, more traditional, rural communities to our larger towns and urban areas. However, there are many commonalities among all the stories as discussed in the *Afterword* at the end of this volume.

Each chapter begins with a story. Stories are the oldest method that human beings use to share important experiences and valued insights. We all cherish stories handed down to us from past generations. We first learn about our world and how it works through the stories told to us in childhood. The most valued insights are often those told through stories our elders infuse with a lifetime of experience.

As Alaskans, we are especially favored to have the rich and dynamic oral traditions of our indigenous communities and of the other cultural groups who have come here to make their homes. It is these traditions that we hope to embrace.

Some stories in this volume describe how communities have tackled various health care issues. In other stories, individuals or groups talk about their experiences and lessons learned through a single project or a long career. There are no set formulas. There are no prescriptions for "strategies that will work in your community." There are, however, many examples of strategies that have worked, as well as examples of barriers and challenges that have to be faced.

The second section of each chapter contains a short discussion called *What Numbers Can Tell Us*. This section was included with the grant writers and program managers in mind, especially those from smaller communities. This section deals with story related data issues. It suggests ways data issues might be handled in a grant application or program report.

A third section, *Things to Consider*, offers some ideas, questions or issues that a reader might want to consider when thinking about how the story might relate to another situation or context. Some suggestions are very concrete, while others are abstract. Some are offered by the local community, others are pulled from storehouse general planning knowledge and principles. Users may find this section helpful in organizing a group discussion or brainstorm session.

The final section, *To Find Out More*, contains a relatively short list of contacts, organizations, plans, web sites or other resources that should be helpful to someone wanting to explore further the issues and problems presented in the narrative. This section also lists the most relevant Volume I chapters for the particular story. For grant writers and program planners seeking a comprehensive public health resource, *Volume III References and Resources: Plan Summaries, Acronyms and Other Public Health Materials* describes a wide variety of existing state health planning documents and other available materials.

We hope that this volume will encourage the sharing of experiences among Alaskan communities in the ongoing quest to build and maintain healthy communities and lifestyles in diverse Alaskan settings.

HEALING OUR COMMUNITY

THE KAKE PEACEMAKING CIRCLE

"What's going on among us is a quiet revolution."

-Mike Jackson

*"We are sparks and together we will start a big fire
that will change things for Alaska Natives."*

-Jada Smith

Circle peacemaking is a group process used for suicide prevention, interventions for alcoholism and drug abuse, domestic violence, personal and cultural traumas, and restorative justice work.

The circle peacemaking process is simple and can be taught by example. A circle deals on an emotional level, in a safe and supported environment, with a range of individual problems. The circle focuses the caring and compassion of a diverse group of people, to improve health and strengthen community bonds.

Peacemaking circles are built on values of loyalty, love and compassion. Participation is voluntary, and the circle is open to all. Each circle adopts its own ground rules. They generally include respect, confidentiality by request, consensus, honesty, and caring.

The Kake Story

(based on an interview with Mike A. Jackson of Kake, Alaska)

Kake's Peacemaking Circle was started in 1998 by the Healing Heart Council, a group of concerned residents who took their name in honor of the Craig Healing Heart Totem. The totem is a symbol of sobriety, of living a drug and alcohol free life, and it is a symbol of healing from all kinds of losses. Kake's Youth Court also uses a peacemaking circle for its restorative justice work with high school age youth.

The Kake Peacemaking Circle meets twice a month. All are welcome to sit in the Circle as either supporters or as those who bring a problem for resolution. The Circle also reaches out into the community, going to people who might benefit from participation.

The first time the Kake Healing Heart Council held a circle, it was at the request of the Alaska Division of Family & Youth Services. A woman in Kake had gone for alcohol treatment thirteen times in an effort to keep her children from state custody. A Circle and follow-up Circles were held and the woman has stayed sober and kept custody of her children. As magistrate for Kake, Mike Jackson has held 80 restorative justice circles and follow-up circles for 60 residents. Each has been a success.

In addition to being the magistrate for Kake, Mike A. Jackson is the president of Keex Kwaan, the Kake IRA Council. He also holds a Masters in Fine Arts from the University of Alaska, Fairbanks. Here Mike tells the story of the changes that have happened in Kake and about the start of the Healing Heart Council and the nature of its work.

"They go around the circle three times; twice to talk about the problem and share insights; the third time is to develop a consensus plan. Speakers hold either a feather or a talking stick."

-Jada Smith

Eagle down symbolizes peace and reconciliation in Tlingit culture.

A Quiet Revolution

"When I was growing up, we never heard of suicides and we hardly experienced alcohol—it's a pretty contemporary thing that happened. I can attribute it to when the logging camp moved in, in 1964 or 1966—210 people from down south came. About that same time the city owned alcohol store moved in here, too. There weren't many deaths to alcohol prior to that that I knew of. When I went out to school I heard about people passing on, but I didn't know what it was from. When I came back I found out the truth—that it was from suicides. At one time there were 21 people that died in one year from suicides. One hundred percent of it was because of alcohol. I doubt if they would have done that to themselves if they were sober.

"We started talking with our father and grandparents and they said it was a loss of souls and a loss of dreams and a loss of hopes. People were moving away from their culture, their traditions and their ceremonies. To me that was real sad. So we were challenged by our elders: 'The (IRA) tribe is good for social issues,' they said. 'Look at it.' So we activated it in 1982, with the goal to move on with programs to address our social problems.

"The local ANCSA (Alaska Native Claims Settlement Act) tribe donated money to bring people from RuralCap and Susan Soule in the suicide prevention area and she gave us money to start a program. We didn't do too much in regard to hiring people, but pointed it towards doing positive things with the elders. It was an integration that worked. Like they said, the younger generation was falling away from the elders and our customs and doing things we shouldn't do to ourselves—like suicide and drinking.

"It came to a head in 1988 when the Anchorage Daily News wrote a week-long article, *People in Peril*. And this made us look right in the mirror. People who had been affected by it were just shocked. In what we call the 'western way,' you have a right to kill yourself whether through alcohol or just walking off a cliff or taking a gun to your head. No consequences. But as tribal people here in Kake, we all are together in our life. We don't lead somebody up the cliff and let him jump. We don't let anyone handle a gun who is intoxicated, if we're around.

"We brought in consultants. You pay for what you want to hear, but we are left. With that realization we said, 'We have to do this ourselves.' There was a long debate about what was right and what was wrong and what was religion, what was tradition, and the common values of love, respect and forgiveness. That sent us on the road of recovery, healing. We haven't had one suicide in years and years.

"The circle is traditional in families and in tribal dispute resolution. In our traditional circles, the victim was the most important part because they had to know that they didn't do anything wrong to deserve what they experienced. You needed to get past blame to mending broken relationships. Mending those relationships took healing words. Like they say, words can be like clubs or spears. But healing words will come like eagle down and will land on you if you let them come from the heart. If you just sit there and let your heart open up and wait for the eagle down to fall on you—that's forgiveness.

“We started our Kake circle after I heard a presentation in 1998 at a Magistrates Conference on restorative justice among the Canadian Tlingit, bringing back their customary and traditional ways of resolving disputes. That just brought it all back, just like a flood. I couldn’t wait to get back home to tell our group. We formed our Healing Heart Council to address the issues of our young people, to make sure they were protected at all costs, and that we celebrate the good side of Kake.

“The Healing Heart name was influenced by the Healing Heart totem that Stan Marston carved and by the ‘Carved From the Heart’ video that Ellen Frankenstein and Louise Brady of Sitka made. We couldn’t believe it, because we knew them all, all the players in it. But we found out what we were doing was just what they were saying—the healing heart—that’s ourselves.

“To encourage the goodness to come out to help one another in our community, to be a better community but also a better people to ourselves. To stop the suicides, to encourage kids to do good. There are so many contemporary messages out there that say, ‘It’s good to drink beer.’ That’s not our way. We have to stop them, because too many of us have already been lost. Thousands of years wasted here in Kake, and that’s way too many years wasted. So the circle heals, celebrates sobriety, celebrates goodness, and celebrates life.”

- Mike A. Jackson, Kake



Photos courtesy
of Merry Stensing



Carved from the Heart

A film by
Ellen Frankenstein
and Louise Brady

An Alaskan, Stan Marston, loses his son to a cocaine overdose. As he grieves, the Tsimshian woodcarver decides to create a totem pole and invites the town of Craig to help. The people brought together in this process tell their stories of loss, intergenerational grief, substance abuse, suicide, and violence. The film connects the process of carving and raising the Healing Heart Totem Pole with these powerful stories and the experience of healing.

Carved from the Heart shows the importance of culture and ceremony for surviving tragedy, and how communities can provide support for their people. The companion film, Words From the Heart, features people from around the world talking about the ways Carved from the Heart has encouraged individual healing and action within their own communities.

Carved from the Heart and Words from the Heart are available from:
New Day Films
(201) 652-6590
www.newday.com

Voices from the Circle

The following people belong to the Kake Healing Heart Council and speak about the meaning of the Peacemaking Circle.

"The circle saved some lives and it works here in Kake, maybe just because people are so generous with their time. With restorative justice the wrong doers are notified that they did something wrong and they are willing to make it right, to mend relationships that are very important in the day to day life in small villages. That's what the circles are about—to make people well, to make sure they can see straight again and make decisions for the generations yet to come." -Mike Jackson

"I was a drug abuse/alcohol counselor for SEARHC (Southeast Alaska Regional Health Consortium) and I used to feel responsible for each person. Now it's not just on the shoulders of one person, but on the whole community—where it needs to be. It is too big, too powerful for one person to have credit for—it's the whole community." -Jada Smith

"The circle has been a very powerful tool among our people, not just now but for generations. When we come together in a circle you can feel the power instantly. It's not just us sitting here. We represent our families, our fathers, our forefathers, our ancestors. It is such a privilege to work with our people. To love one another, to honor and respect each another enough so that we not only live for today, but our lives go on through our children and our grandchildren. The circle is a 'living treasure' because it takes people who are alive and confident and powerful and concerned enough to come to the circle to make it work. It is hard to step out and do your part and talk from the heart, especially for our young people, to speak from the heart sincere words of compassion, love and concern. I know that it will be used for a long time because even now our children are using it. You can see into the future when you look at our children and it is a hopeful future—there's not one who's

going to be defeated. We are not victims any longer. We are survivors. Even gone past survivors. We are now empowered."

-Jada Smith

"There's a real service the circle has provided. I know that some of the people we have seen and talked to and encouraged and all that, there's been a marked improvement in sobriety. The youth are forming their own circles and doing a great job at it. It's a real asset to this whole community and to the world." -Stu Ashton

"I like to see people heal. I want to express just a little bit what the power of love does to people—from concerned people, concerned, so concerned that they want to reach you no matter what. My own story of what happened years ago started out with a person that had an act of love, wanting someone to change really badly. It changed our lives." -Evans Kadake

"To me the circle is about compassion. We've been working with it in the justice system, but also we've been using it as an intervention, supporting, uplifting people. We don't just do it when someone's in need. We do it when we know they're doing good, to encourage them, and that seems to be helping. They know that people care for them." -Justin McDonald

"The other thing I've see in the circle, the people there in support are also being touched by it. You hear people say they learn about themselves. That's what really made me a strong believer in the circle. We can have from 5 up to 30 people and every person is leaving feeling good, their heart feeling strong, as well as the person we are gathered there for. We heal the community that way, by helping other people. After I started giving my time to the kids, the more I gave the more I started seeing that it was healing and strengthening my spirit, my soul, my heart. I get these results just by giving of myself. And it doesn't take any money. No one has to pay for it."

"Other approaches to suicide prevention don't work for Natives. The answer is in the circle where people can see the caring they need and feel a part of the community. The circle is a way to deal with intergenerational grief and learn about the past and move on. We need to quit hiding and blaming. It takes the simplest things ... You don't need a big degree or mountains of money. You need to laugh, to cry, to talk. The more you give, the more you get back."

"I've seen the immediate effect the circle has on the people that are there for whatever reason. Everyone leaves here feeling good. Everyday you are going to learn something; everyday you have to give something, too. Keep that balance. You need to have that laughter, need to have that crying, need to have that nurturing, need to have the caring, the giving. All of these things play a big part in the circle." -Paul Aceveda

"The goal is a healing community, for the young ones. The challenge is to start sooner, in schools, so kids can see alternatives to resolving problems. The Tlingit way is not punishment; it is nurturing."

"We are rebuilding the community. It's like the rivers—flowing peace and accepting each other—enriching a new family. If we're going to get healthier as a people, as a family, as a community, as a nation, then those very institutions that govern us have to take a good look at themselves and see how they can start to complement our efforts and help us return to the place of spirit. And perhaps we can help them. When people in the communities realize they have something very important to give, a very, very precious gift to give, then maybe the institutions will realize how dysfunctional they are. That's going to be a healing for the communities, for the families and for those who are caught up in the system that has failed us horribly since it's been here."

"We need to work together. We need to complement each other's efforts and we need to put back the spirit into everything we do. In that way I think that we will have hope. The circle is just a way of sitting and counseling on an equal basis. This is a starting place that will get us back to a healthier place. All are welcome to sit in the circle and gather strength and learn and grow together. We are going to rebuild relationships again. Hopefully, people will realize that they are very, very important and that they've got the answers inside them and maybe they'll start sharing them a little more. I'm grateful for that opportunity to encourage, to help us get back to that place." -Harold Gatensby

"The circle, I wish that I had that when I was a teenager, I might have saved myself a lot of grief. I think that since being with the circle, I've seen lives change, so it can't be anything but good as long as the people are coming, have something valuable to share." -Ned Ortiz

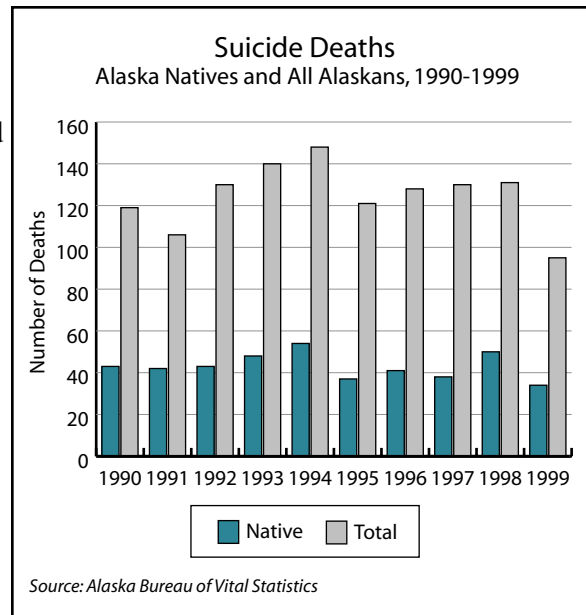


WHAT NUMBERS CAN TELL US

Suicide in Alaska

Ninety-five Alaskans died from suicide in 1999. In another 26 cases, the “intent” of death was classified as “undetermined”—in other words, it could not be determined if the death was a suicide, homicide or due to an unintentional injury.

Suicide was the sixth leading cause of death in Alaska. Only five states had higher suicide rates than Alaska in 1999. The rate for the United States was 11 per 100,000 people compared with the rate of 17 per 100,000 in Alaska. Men were three times more likely to commit suicide than women. Guns were used in 58% of the suicide deaths. (Alaska Bureau of Vital Statistics, 1999 Annual Report, www.hss.state.ak.us/dph/bvs/statistics/99annualreport.htm)



Alaska Natives were twice as likely to die from suicide as white Alaskans—that is, the rate of deaths per 100,000 people was twice that of white Alaskans, and nearly four times the overall rate for the United States.

THINGS TO CONSIDER

Not every community is the same. Only the community can identify a strategy that will work. Peacemaking circles may be a powerful tool to address the physical, psychological, social and spiritual dimensions of a variety of health issues.

Based on Kake’s experience, the following are some things other communities might want to consider:

- Communities can learn from each other
- Some solutions involve going back to traditional ways
- Improving community health is a long process that evolves in response to leadership, information available, community readiness and learning what works
- Listening, respect, compassion and trust are healing
- Individual healing heals communities
- A Circle is simple; training is available; you can do it
- Circles don’t take money

Restorative Justice & Peacemaking Circles

Restorative justice is an approach that holds offenders answerable for their behavior, expecting them to undertake efforts to repair the harm caused to their victims and to contribute to restoration of the public trust.

Restorative justice shares an emphasis on dialogue, negotiation, and problem solving with the Talking Circles of many indigenous peoples. Alaska Natives, American Indians, Canadian First Nation people, and Australian aboriginal people all work within their communities to establish Peacemaking Circles as alternatives to criminal justice and court systems.

Restorative justice sees crime as a break in the relationships between people. The goal of restorative justice is to restore the balance, peace and status of victims, communities, and offenders by asking them three fundamental questions: What is the harm? What needs to be done to fix the harm? Who is responsible for this repair?

The restorative approach promotes offender accountability and victim restoration. Restorative justice enhances public safety. Offenders receive support and supervision and help to change. Victims participate in developing sanctions and defining what it will take to remedy the injury done by the offender.

Restorative justice works as a collaborative effort among state agencies, the community and the victim.

Peacemaking Circles allow a group of people, including the offender, victim, and community members, to respond to a particular crime or incident. They create a place where the members work with accountability, restoration, and healing.

"A healing-based community justice model starts from the recognition that both offender and victim are part of the same community. Each victim and each offender is also part of a family. What affects the offender and the victim will also affect families, as well as the community as a whole. It is seen as a community responsibility to deal with the offender's actions and the underlying causes of his or her criminal behavior in the community."

*-Understanding the
Role of Healing in
Aboriginal Communities,
Marcia Krawill, for the
Ministry of the Solicitor
General of Canada
July, 1994*

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About Restorative Justice:

State of Alaska Division of Juvenile Justice
(907) 465-2212
www.hss.state.ak.us/djj

National Institute of Justice
U.S. Department of Justice
www.ojp.usdoj.gov/nij/rest-just/index.htm

Alaska Native Justice Center
(907) 278-1122
www.ciri.com/about_ciri/anjc.htm

Center for Restorative Justice and Peacemaking
University of Minnesota
(612) 624-4923
www.che.umn.edu/rjp

Native Law Centre of Canada
University of Saskatchewan
(306) 966-6189
www.usask.ca/nativelaw/intro.html

Department of the Solicitor General of Canada
Restorative Justice: An Evaluation of the
Restorative Resolutions Project
www.sgc.gc.ca/publications/corrections/199810b_e.asp

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 4. Substance Abuse
Chapter 5. Mental Health
Chapter 6. Education and Community-Based Programs
Chapter 9. Violence and Abuse Prevention

A TRADITION OF LEARNING

INNOVATION AND TRADITION IN THE YUKON KUSKOKWIM DELTA

What the federal and state governments can do is offer mutual respect and assistance. They must be willing to give control of local issues back to Alaska Natives. They must step aside in many areas so the Alaska Natives can attempt to reconstruct honorable and dignified lives for themselves.

-Alaska Natives Commission Report, 1994

This story focuses on reviving and strengthening traditional assets and incorporating them into the service delivery system to make villages healthier. The storyteller is Joan Hamilton, a native of Chevak and Director of the Yupiit Piciryarit Museum in Bethel.

In the 1990s Joan Hamilton directed an alcohol and drug abuse demonstration project, Chemical Misuse Treatment and Rehabilitation Services (CMTRS), funded by the federal government's Substance Abuse and Mental Health Services Administration. Three villages in the Yukon Kuskokwim Delta participated in the project along with Bethel as the regional office. The objective was for villagers to come up with ways to reduce barriers to alcohol treatment. The local counselors had to find alternative ways to approach treatment.

YUP'IK AND CUP'IK APPROACHES TO A BETTER SYSTEM OF CARE

"Nordstrom's in the Bush"

"Normally there is just one staff person in a village. It is hard working alone in a village and being supervised from Bethel or beyond. And it can be really hard on the counselor. So one of the first things we did was to provide some local support.

"It took me a long time to convince the State and the Feds that you absolutely need a Policy Steering Committee in the villages themselves. The response was, 'They don't know how to make policy.' Well, how did 'they' survive as a culture for over ten thousand years if, in fact, they don't know how to make policy!

"I modeled our approach to service delivery after Nordstrom's. People crack up when I say that. Why Nordstrom's? I love their customer service that allows the salespeople on the floor to make decisions right then and there. They don't have to call some office to ask, 'Can I do this? Can I do that?' Nordstrom's knows how to delegate and encourage professional growth.

"I think it is important to have independent, strong counselors. They need to think for themselves, have their own ideas and be able to solve problems. You need creative problem solvers and thinkers for services. I wanted the counselors working out in the village—sometimes an hour or more from Bethel by airplane—to be trained well enough to be able to make decisions themselves.

"I'm from one of the villages, so I know what it is like. Each village has so many political factions, a microcosm of the U.S. So in order for the Policy Steering Committee to succeed, I insisted that the counselors identify how many political units there were in their villages. One guy identified six groups. And I said, 'Okay. You are going to get a representative from each one of those six groups.' 'But they won't talk to each other.' 'I don't care if they don't talk to each other. They are going to get together.'

“And everyone who was asked joined the Policy Steering Committee. They worked cooperatively. There was balance because of their different backgrounds, but they did it respectfully for the ultimate good.

“The counselors then had somebody to fall back on for support, especially the elders, who made a regular habit of just walking into the counselor’s office saying, ‘How are you doing? How are things going?’ You know, just to let him know, ‘We’re here for you.’ And that was successful.”

Access to the World

“At that time, the telephones were restricted. The village counselors could only call from the village to the central office in Bethel. They couldn’t call each other. And I insisted on unrestricted access. Unrestricted access provided them the opportunity to give and seek support from each other. And it allowed them the opportunity to consult with other professionals.

“The counselors went out to workshops. Many of them didn’t have a formal background in the substance abuse field. They were encouraged to increase the network of people they could consult with, and they developed ties not only with professional agencies in Bethel, but also with Anchorage, Juneau, Albuquerque, and Washington D.C. It was very important to them in their professional growth. We broke the envelope on the restrictions.

“When they learned something at a workshop, they had to go back to the village and go visit an elder and talk to them about what they learned. This was critical. They were teaching the elder about what they learned outside. And it turned out there are many parallels to our traditional ways of doing things. This reinforced the learning of new skills.”

Two World Views

“I felt it necessary to have a non-Native social worker to help us write the therapeutic values to the Yup’ik and Cup’ik treatment modalities and to evaluate the clinical process. On this project we’re all Native, and sometimes if you are all of one worldview, you can miss key components.

To be successful we needed a social worker with years of experience. Practical experience is important.

“Fortunately we found the right person. She had worked with children. As an example of her most successful counseling sessions she said, ‘The best place to counsel children is in the park because they are having fun and you can talk to them while they are playing.’

“She was wonderful. We analyzed each of our traditional treatment modalities and learned to identify their therapeutic components. As a non-Native counselor, she could easily identify what people were saying, and she spelled it out for us.

“The elders also understood and used the therapeutic components in each activity. You know, you are creating a bond between people. You are teaching new skills, and you are teaching them about environment, about the behavior of the environment, so that they connect. These activities create that bond that is necessary for a sober, healthy person to connect with people around them and with the land.

“And the land is important to us. That connection with the land is basically a connection to our ancestors. Because we believe their essence stays there with us. These things are much easier to teach in the context of a traditional activity, rather than in an office setting.”

Training and Credentialing

“Initially there was a lot of resistance on the part of the counselors to any kind of training in Anglo-European ways of therapy. But I explained that they were going to enhance their knowledge and that we absolutely need to talk to the people in Washington D.C. and speak their jargon. That made sense to them.

“The first two years were heavy training. We talked to each of the counselors. ‘We need to show that you are credible. In this world you need to be certified.’ We had all of them certified—legitimately. In addition, the counselors were not only bilingual but enmeshed in traditional activities. They ranged from the late twenties to early 60s. Their patterns of life

had been established even though they did not have any formal training. It is much easier to educate someone to be a counselor when his or her life is in order.

“One of the counselors in Level 1 training felt ostracized by the group. Before she had gone to training, I talked to the teacher and explained, ‘She’s very intelligent, but she may have problems with some foreign concepts in English words. So if you will explain the words to her, I think she’ll do very well.’ The teacher later told me that the college graduates in the class came to him complaining that she could barely speak English and they were insulted to be in the same class with this ‘dummy.’

“Well, exam time came and she was at the top of the class of 25 people. When the teacher announced that she scored the highest in the class, some of the students walked out of the room. Isn’t that fun! Absolutely fun! She was 63. She’s not a babe in the woods—in the tundra!

“We would like to have elders credentialed because of their knowledge base. Oftentimes, people who are interpreting for them do not have the fluency that the elders have in their language. For instance, while reviewing raw video footage, I had my eyes closed and was listening to the interpretation. At one point, I heard a translation and I said, ‘Did the elder shift in his chair?’ The elder shifted in his chair. Even though he didn’t speak English well, he knew the interpretation was wrong.

“The interpreter translated, ‘I feel really *bum* about how people are *bum* to one another.’ He had actually talked eloquently about his concern that people no longer shared compassion for one another. This was one big difference between today and the time of his youth. The elders have a vocabulary that is the envy of all of us. Compared to them, we are just at the kindergarten level in the Yup’ik language.

“So we’d like some kind of credentialing for these men and women, but it is something that we still need to work on. We’re aware that licensing is a way to keep people out. It’s building territories, job security, and all of that.

“The act of learning, of acquiring knowledge, is very Native. But the Anglo-European way of regurgitating it back to the professors is very non-Native. The Yup’ik and Cup’ik way is to teach the child to look at things critically from day one, while in the Anglo-European formal education system, you are not supposed to think critically until you are in graduate school.

“I think in order for anything to survive, it cannot remain static. It is the same with culture. In this world you have to think carefully about what you choose. Until 30 or 40 years ago, things could be incorporated at a reasonable rate. When iron was introduced, we adopted it for our ulus. But suddenly the world began to change in leaps and bounds, and changes just were dumped on us. I think for us it was in the ‘70s with oil.

“These changes forced us to question and examine things a few years ago. We liked the way of the villages: trusting one another, taking someone at

“One time I was making a presentation to a community about the therapeutic value of traditional dance, and my mind went totally blank.

An elder raised his hand and said, “If you don’t mind, I’ll tell you what I understand you use dance for. Then he listed the therapeutic components of dance that we had written down with the help of a social worker—and he added a few more.”

face value. We like how we treat our elders. In Bethel, gray hair is a great plus for getting a job. Deference is given to age. In some cases it is not, and we need to correct that. I think these basic Yup'ik and Cup'ik values need to be retained.

“It is possible to maintain our culture and still incorporate other ways. You have to learn in order to survive in this changing world. It is extremely important to survival. But I get nervous when people say ‘traditional ways’ are the only way to go. It is learning that is traditional, not just what you learn. And it is the knowledge base creates a sense of security that people who are into alcoholism have lost touch with. Knowledge is necessary for a healthy community.

“There is a Yup'ik saying: ‘If you do not learn, you will die.’”

Tradition as Treatment

“In the Yup'ik and Cup'ik region we tend to think of our problems holistically, rather than just as alcohol abuse, wife abuse, child abuse, etc.. We see it as intermingled. When we sought innovative ways of providing treatment in villages, we came up with traditional cultural activities. I think the theme in the back of it all is chaos versus order and discipline. Substance abuse—especially alcoholism—is a form of chaos. An alcoholic family is in chaos. Discipline and order are out the window. You never know when someone is going to get drunk and mean. The children don't know when or where their next meal is coming from.

“But the traditional ways of life teach demanding skills. They create order and demand discipline in place of chaos.”

Suicide and Dance

“When I began as director for the CMTRS project, I thought I firmly believed in trusting the judgment of the villagers, until one time one of the lead counselors called me up and said that there was a suicide pact among a group of ninth grade girls. They had all decided they were going to commit suicide.

“When the counselor got wind of the suicide pact, she asked who the prime movers were. And she went after those folks. They didn't want to talk at all. The parents were scared out of their wits. The village counselor told me that she wanted the girls and their parents to become involved in Eskimo dancing as the main treatment.

“So my first reaction was *liability*. As a director, you are always thinking liability every time you turn around. And so I asked if they had called Mental Health for advice—YKHC has licensed professionals who provided incredible support to the counselors in the villages 24 hours a day. Yes, they had consulted with Mental Health.

“And I talked to their Mental Health supervisors as soon as I could. I said that I really had doubts. But the psychologist and I sat down, and he explained that it had to do with the sound of the drum. ‘If you have a person come into dance, especially this young girl and her parents, you are creating a setting that is fun. It shows that life is fun. The girl is learning a new skill. She's exercising vigorously, and she's also among her peers, who are also into Eskimo dance, and they all just love it.’ They do love life, you know.

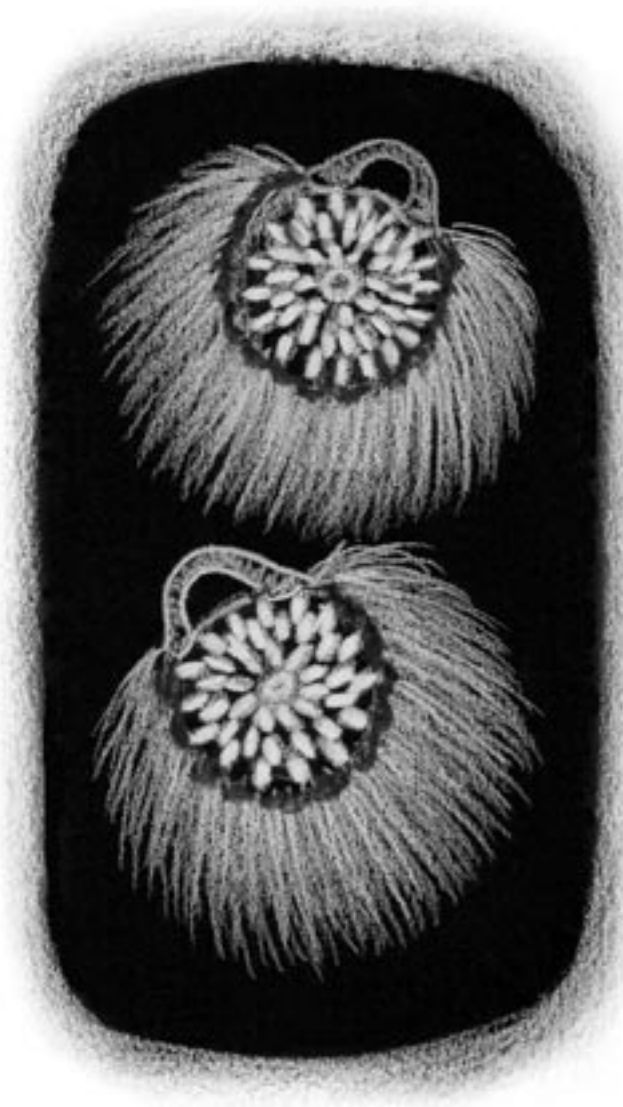
“They are learning traditional stories as they are learning the Eskimo dance, because story is a part of Eskimo dance. And when you make a mistake in Eskimo dance, there is never, ‘No, No, No! You shouldn't do it that way!’ When you make a mistake, no matter whether you're young or old, everybody bursts out laughing, including yourself.

“So you learn that everybody makes mistakes and even mistakes can be fun sometimes. But then rather than just leave you alone, they will say, ‘You were doing this. But I think if you try this, you will find it will work better.’ Then you make the corrections. And the corrections are made in the spirit of love, cooperation, and fun.

“When you talk about story telling and dance, you are talking about appropriate behavior at the appropriate time. If someone has hurt your feelings, we can usually make fun of that person in dance. Everybody knows what is going on

and is enjoying it. At the same time, you are getting your feelings heard, getting your feelings out.

“So, that girl is still involved in dance to this day, almost ten years later. None of them committed suicide. And it was a lesson to me to realize that I wasn’t really trusting what the villagers were bringing fourth. So after that, even though I continued to question it, I came to trust it. But I still asked them, ‘Did you consult the Mental Health people?’”



Children

“Another problem that the counselors addressed was treatment of children. So they went to the home of the kids they were concerned about and spent as much time as possible to mentor and model the role of the parent. This seemed to work, but we knew that, as counselors, they were going to have many people talk to them after hours, and we didn’t want to burn them out. They were told to adjust their schedules so that there could be a supervisor available to call on.

“They came up with schedules that allowed them to go to these homes on certain days as part of their work. It got to the point that DFYS consulted with them freely, and they enjoyed working with the counselors and relied on their assessments for immediate feedback.”

The Steam Bath

“One of the most successful traditional treatment modalities is the steam bath. They still use it here in Bethel. When you steam, you don’t do it by yourself. You do it with other people. You can’t be drunk. They’d boot you out. In the steam bath you are creating a bond between people. You have a core group of regulars. Everyone talks to each other. For people who are having troubles, it’s important. They ask how you are doing, and you are creating support. They tell stories, laugh, and have a merry old time.

“In Bethel there was a young man—you couldn’t get him to say boo. He was teased a lot. You could say, ‘Go jump in the lake,’ and he’d say, ‘Okay.’ One day in the steam he started talking. He said, ‘I don’t like you teasing me.’ He actually told them he didn’t like the rudeness. They were congratulating him all over the place. Things happen in that context. It really removes barriers.”

Hunting and Fishing

“It is normal for clients to give excuses to avoid therapy. ‘My family needs me.’ ‘I have to go hunting for them.’ One counselor wanted to see this guy, and he said, ‘You need to come to treatment. Otherwise, I’ll have to report you.’ He said, ‘I really, really want to, but I need to go fish for my family.’ So the counselor said, ‘Great! Let’s go fish for your family.’ And while they were fishing for the family, they did the counseling.”

“There was a couple that had been in treatment many times with no success. So the counselor took the man hunting. When you are out hunting, sometimes you sit down and relax because you are tired or hungry. And when they sat down for lunch, the counselor started talking with him about what was going on in his life. And after they were all done, the guy just laid back and he said, ‘Oh, this is wonderful. This is just like treatment, except I want to be here.’”

Seeing the Positive and the Negative

“Our way is to see the negative, but also to see what is being done right. We build on strengths, but never ignore weaknesses. Correcting the problem is your ultimate goal in the background.”

“Whenever a client in counseling fails, you focus on the positive. ‘You might want to try this next time.’ ‘See how this works.’ Instead of saying, ‘You have to stay sober. You have to!’ No. You don’t have to stay sober. Nobody can make you not take a drink, but are you willing to pay the price, go ahead. Most of them fortunately, say, ‘I don’t want to pay the price.’”

“We had one who wanted to pay the price. We even sent him out to aversion therapy. No avail to this day. So, you know, we haven’t been successful with everybody.”

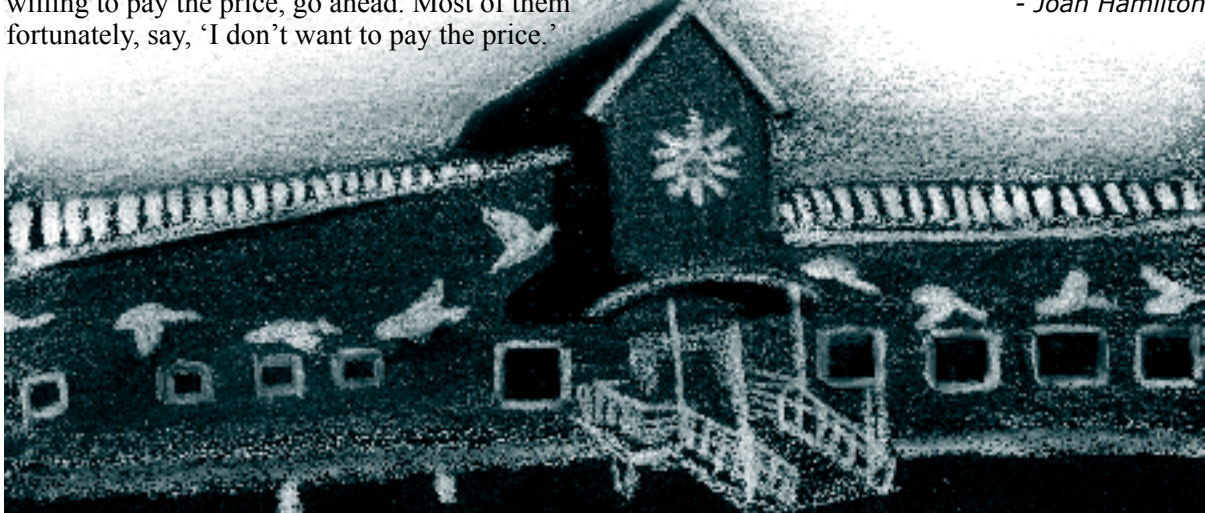
The Yupiit Piciryarait Museum

“These experiences led me to a better appreciation and understanding of traditional strengths and to take my current job as Museum Director. I thought, ‘Just the perfect opportunity for a prevention program!’ I mean prevention in the sense of helping people, especially young students, by teaching them their history and how their ancestors were able to maximize use of everything in a seemingly very harsh environment—and did really well.”

“I teach them their history and the importance of traditional things like dance and working in the community. I talk about traditional technology and the kind of knowledge needed to invent and use it ... physics, math, biology and even human kinesiology, for lack of a better word. I talk a lot about how different artifacts were made and about how the availability of materials influences everything, including the evolution of things over time. I also teach them to incorporate what they see and hear to maximize their own life.”

“I’ve found that the kids become very impressed with themselves, because they realize that they have the same genes, the same ‘blood’ and the same capacities. So, if they are not doing well, it is, in essence, not because they are not capable. They just haven’t taken the opportunity.”

- Joan Hamilton



WHAT NUMBERS CAN TELL US

The Institute for Circumpolar Health Studies at the University of Alaska evaluated Chemical Misuse Treatment and Rehabilitation Services (CMTRS). Their report is available through their web site at www.ichs.uaa.alaska.edu and through the University of Alaska Consortium Library.

The evaluation compared CMTRS communities and communities of similar size that used typical Western methods for substance abuse treatment and prevention, such as Alcoholics Anonymous (AA) groups. Individuals and groups were interviewed in each community. People in all villages agreed that substance abuse was a major problem, and that eroding traditional values and decreased reliance on the elders contributed to drug and alcohol use. CMTRS was credited with reducing alcohol problems in the villages. Local control of programs, training residents as counselors, and use of traditional activities in treatment were identified as strengths of CMTRS.

Evaluators measured the number of clients, the sex, age, income, marital status, employment, and legal status of clients in treatment. Communities with CMTRS served more female clients, more clients with full-time jobs, and more clients with behavioral and social problems.

Public safety data, such as alcohol-related crimes and arrests, did not show a significant reduction in crime or incarceration rates in CMTRS villages. There was no clear impact on hospitalizations or placements in child protective services, but CMTRS villages had lower and declining rates of placements in youth correction services, suggesting perhaps that they were on the path to improvement.

THINGS TO CONSIDER

Today's Alaska Native villages and towns are very different from the communities of 150 years ago. Today's communities are year round, permanent and usually include schools, clinics, churches, stores, jobs, a cash economy, modern transportation, and modern communication facilities.

A long succession of traumas accompanied the changes of the past 150 years for Alaska Natives: epidemic diseases, famine, forced settlement and resettlement, prohibitions on religion, language, and other cultural practices, the removal of children and the sick from the community and the increasing commercialization of subsistence resources. Restoring a balance to today's communities does not mean a re-creation of pre-contact times. Rather it means restoring and strengthening those traditions, values, institutions, and techniques that create a healthy community today.

When people think of "infrastructure," they tend to think of physical things like buildings, vehicles, telephones, computers, and furniture. When people think of social services, they tend to think of something that happens away from normal life in a hospital, clinic or office. But infrastructure and treatment also include knowledge, skills, information, shared values, activities and the various ways communities or groups organize to accomplish what they want to achieve. The

Neighborhoods of Alaska's cities, and other communities along the roads, railbelt and the coast, have grown and changed greatly in recent decades as have many Alaskan Native villages. They have absorbed immigrants from other parts of Alaska, other states and nations. They have grown as economic and military activities have changed. Maintaining a balance is especially important in these communities.

"One village focused on the individual and took a client to client approach, another was more communal. The response to a suicide was to have a community potluck where people shared their feelings and thoughts. And there was community healing. You don't go into a village and say you're Yup'ik. This is the way you have to approach things."

-Joan Hamilton

CMTRS project demonstrates how important traditional knowledge and activities are in building and sustaining a healthy community.

The following are some questions and ideas you might want to consider when you think about creating or improving programs in your community.

What role does your village, community, neighborhood or organization play in designing, managing and controlling its human service programs?

What can community organizations do to establish and maintain a healthier community or neighborhood?

Small communities or neighborhoods with strong cultural traditions and programs, in general, should look around at the knowledge base and organizations within the community.

CMTRS identified the exclusion of elders from an active role in the human service delivery system as one of the more important barriers to building a better system. By excluding or marginalizing elders from the human service delivery system, the system had squandered this important resource that could help build healthy communities.

For some communities, important partners include religious organizations, secular organizations, or businesses. These organizations have a stake in the long-term well being of the community. Collaboration can take the form of shared use of facilities, co-sponsorship of events or joint planning activities of mutual benefit.

What traditional activities in your community might help build a healthier community?

Religious and secular holidays, arts and music festivals, whaling celebrations, potlucks, potlatches, athletic activities, folk dancing and other activities provide opportunities to promote alternatives to alcohol and drugs, encourage healthy life styles and help develop a stronger sense of community. Probably the most valuable piece of infrastructure for all Alaskan communities is opportunity for exercise, quiet, fresh air, and appreciation of nature.

TO FIND OUT MORE

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Division of Alcoholism and Drug Abuse
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(907) 465-2071

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 4. Mental Health
Chapter 5. Substance Abuse
Chapter 7. Health Communication
Chapter 9. Violence and Abuse
Chapter 26. Public Health Infrastructure

NOTES

7 GENERATIONS

TAKING OWNERSHIP OF ENVIRONMENTAL HEALTH

"Our leaders were instructed to be men of vision and to make every decision on behalf of the seventh generation to come; to have compassion and love for those generations yet unborn."

-Chief Oren Lyons

The following story is about acquiring new technical knowledge and skills to solve new types of problems. The story also focuses on respecting and strengthening traditional ways and values as new knowledge is blended into village life to make healthier communities. The storyteller is Bill Stokes, Environmental Specialist with the Alaska Department of Environmental Conservation (ADEC).

Sitka and Southeast, 1972–1993

"I worked for the Alaska Lumber and Pulp (ALP) mill in Sitka for 21 years before it closed in 1993. I had worked my way up to the Environmental Department's 'Lead Operator,' responsible for all of the water and wastewater treatment systems at the Sitka Pulp Mill. I was also the lead hazardous materials (HAZMAT) responder for the Pulp Mill, six logging camps and a sawmill in Wrangell. By the time I left the Sitka Pulp Mill, I was qualified to run every type of water and wastewater system in the U.S. I also understood hazardous materials and oil spill response because I was the lead HAZMAT responder who would clean them up for the Sitka Pulp Mill, their sawmill and their logging camps.

"When the mill closed, I planned to go back to school for an environmental engineering degree. Then the Alaska Department of Environmental Conservation offered me the Bethel Field Office Manager position and I just couldn't pass up the chance to play with 58 village water systems."

Bethel and Southwest, 1993–1994

"When I arrived in Bethel it was clear that the villages of the YK Delta sorely needed all these practical skills. The Bethel Office Manager's responsibility was primarily to enforce regulations. Technical assistance was a distant second. I reversed those priorities and made technical assistance the focus. The villages needed practical technical assistance knowledge and skills.

"I soon realized that village tribal authority was also an essential part of solving environmental problems. Both the state and federal governments historically had used a very heavy regulatory hand with these villages. 'You *will* do it by the book. Here are the regulations.' The village's authority and desires had not been included in either defining the problem or in formulating the solution. If you were from ADEC, the villagers' expectation was that you were there to yell at people, issue threatening letters and punitive actions. I didn't find this tactic at all useful because it just didn't make things better or really solve the village's problems.

"Historically, the ADEC provided very little technical assistance to the villages and had lacked a basic understanding of how to teach and transfer the necessary technical knowledge in the context of the culture. Learning traditional teaching methods was a very important missing piece in the picture I saw of how the ADEC operated in the villages of the YK Delta.

"While living in Sitka, I also commercially fished and I got to know the villages throughout Southeast. At the Sitka Pulp Mill, many of the mill workers were Southeast Natives. Through these Southeast Natives I learned the importance of cultural processes: showing respect for elders, knowing how and when to talk, asking permission, and understanding that the tribal government is a valid and real government with an important role to play. The more I learned, the more I was amazed at how the Native people, and their tribal governments, were the objects of scorn and prejudice."

-Bill Stokes

"So in visiting the YK Delta villages, I went in to watch, to listen and to learn. I learned their traditional system for teaching and learning, and I worked hard to find out how I could best be of service to the village. I never just barged in. I always asked permission to visit first. It was a conscious choice to be different. Then and now, when I visit a village, I wear a bright orange baseball hat so everybody knows who I am and I can't be confused with anybody else.

"It is my experience that Alaska Natives have a tremendous respect for practical knowledge that will make a difference in their lives, especially in the lives of their children and elders. When the villages understood that I was a skilled water plant operator, I was really in demand and I made myself available. Every time I go to a village, I make it a point to talk to the water operators to see if they need help or training. Many times I've been up at 2 o'clock in the morning assisting the village water plant operator to get the water plant working properly.

"As I did water plant operator training in the villages, I would explain my view of the technical assistance world from my eyes and ask: 'If you want to properly operate your water treatment plant, it is your choice. You live here. If it is not important to you, you won't do it and I am going to leave. But if it is important to you, I will stay and help you in any way that I can.'

"This is a very different mind set from 'the regulatory process.' When the water plant operators and the village residents understand the importance of safe water for the whole village, then regulatory compliance happens as a matter of course. The village gains a greater appreciation of the role of the operator and chooses to make the drinking water safe where they live. In this process they come into compliance with the regulations, but compliance is not the objective of what they are doing. They are working to make their village safe and improve their quality of life."

Developing the Village Environmental Assessment, Anchorage, 1994–1997

"It was during this time that I worked with traditional Yup'ik villages that I began to understand the importance of ownership to making things work in the villages. In late 1994, I moved to the ADEC Anchorage Office to apply my approach statewide as part of a new ADEC Program called Rural Issues. Simon Mawson and I now had 218 villages to work with. We decided that we would be the most useful if we made our main charge to provide environmental education and technical assistance to the villages.

"Between 1995 and 1997 we developed a 'Village Environmental Assessment' process that was based on the concept that villages could, and would, address their own environmental issues if they developed 'ownership' of both the problems and solutions. At their invitation, I would go to a village, detail all of the environmental issues that I found and, where possible, suggest practical village based solutions that the villagers themselves could implement.

“From the very beginning, I designed the Village Environmental Assessment for the Village Councils and not for the regulatory agencies. I never ranked the environmental issues because that was the Village Council’s responsibility. I would present the environmental issues that I found to the Village Council and say, ‘This is what I see as environmental issues in your village and some possible village based solutions. You decide what you want to address and I will help you in whatever way I can.’ I never quoted a state regulation or said, ‘You have to do this.’ What I said was, ‘You live here. Choose what is important to you.’

“The concept was an immediate success for the villages, and the more I used it, the more I learned about how to help the villages achieve what they wanted.

Kids

“The two most useful resources for getting anything accomplished in a village are the elders and the children. If you can get either of these groups on your side, the job is as good as done. I try to go to a village a day before my scheduled meeting and visit with the school kids first. I explain why I am there and what I am trying to help the village with.

“By the time I meet with the council that evening or the next day, the whole village would know why I was there and what the issue was. It would now be a village wide issue. I didn’t have to try to convince the Village Council there was an issue that they might want to address. Instead, it would be the mothers and elders who were getting a hold of their brothers, sons and nephews in the Village Council and saying ‘fix this problem now.’”

“School kids are so important. I teach from kindergarten to high school to whichever class will invite me in to explain my visit. I think that kids from the 4th to the 8th grade are the most effective for getting the word out. Fourth graders really get it! When you have 200 kids going home and asking about the water or when you have 50 kids asking the water plant operator what the chlorine residual is, the village has ownership!”

Oil Spill Clean-up

“Sometimes you don’t have the luxury to plan a visit. You are reacting to a crisis, but the principle is the same.

“One village called me because they had a large oil spill. A snow-go accidentally cut the oil line to the washeteria and spilled about 2,000 gallons of diesel on the ground. I went out immediately. The villagers showed the spill site to me and asked what I was going to do. I asked them, ‘What are you, as a village, going to do? This is an oil spill right in the middle of your town. If you don’t clean it up, it is eventually going to get all over the village. You are going to smell diesel fuel all summer long, maybe for years. There is also the potential for fire. Are you sure this is something you want to let happen? I can show you how to clean it up, but it is your decision.’

*“I was in a village and the drinking water was truly terrible. So I gave the school science class a chlorine test kit and they tested the chlorine residual **every day**. Don’t you think the operator wasn’t on his toes! When they found unsafe water, the whole village knew about it.”*

"As part of a 7 Generations class conducted in the village of Emmonak, I also gave an 8 hour refresher class on how to prevent, contain and clean up oil spills. Not even a month later they had a large oil spill only 200 feet from the Yukon River and it was right during break up. They quickly built an ice berm around the spill and it never got within 150 feet of the river. They trapped and cleaned the fuel oil spill up before the ADEC got there."

"I explained that they had two choices on how to clean up an oil spill. They could call in a properly certified HAZMAT team to clean it up. That's expensive. On the other hand, the owners of the facility could clean it up. Since the village corporation owned the tank farm and the village people were members of the corporation, they legally could clean up the oil spill themselves. I gave the interested villagers four hours of oil spill response training and these villagers were out there past 2 AM every night cleaning up the spill and collecting the oil. In four days it was gone. A major oil spill was reduced to nothing.

"This village had had oil spills before. HAZMAT crews had come in to the village to clean it up. They would just put the fuel it into containers and haul it away. All the associated costs of the cleanup would be charged to the village. The village didn't know that they could clean it up themselves. No one had shown them how, and they didn't know that they could actually keep the fuel oil. It was the fastest and easiest way to clean up their fuel oil spill. At a value of almost \$200 a drum for #1 diesel, you had villagers lined up to recover the fuel oil. Ownership!

"I went back two years later in response to another oil spill, but it was cleaned up before I got there. The village knew how to clean it up. It was their problem. They fixed it. Ownership!"

7 Generations

"By 1997 I had conducted more than 20 Village Environmental Assessments statewide and the requests from the villages to do them far outstripped my ability to actually do them. There just had to be a better way. After wrestling with several alternatives, it became very apparent that I needed to develop an environmental toolbox that allowed the villages to conduct their own environmental assessments and take ownership of both the problems and solutions processes. Over the course of several months I took all the concepts and lessons that I had learned and developed them into a rough draft of what later became *7 Generations: Addressing Village Environmental Issues for the Future Generations of Rural Alaska* (Suanne Unger et al, March 1999).

"The 7 Generations concepts were the next logical step in promoting environmental ownership by the villages. The manual helps the villagers identify and address their own environmental issues. It is a resource book that teaches the village how to put together a planning team, how to do its own environmental planning survey to identify community priorities and how to do a comprehensive technical survey to help identify problem issues that may need outside assistance or advice. The Native Consortium, Chugachmiut, hired a professional schoolteacher named Sue Unger to help me with this process. Sue's keen insight and ability to articulate the 7 Generations ideas were absolutely essential in making the manual a reality.

"In September 1997, the first 7 Generations environmental workshop was held in the Village of Aniak. Twenty-two village environmental coordinators from around the state attended. The workshop lasted four days and many village environmental problems and possible solutions

were discussed. A workshop participant from Mountain Village realized that the village dump had many lead batteries and was right above the river, their source for winter pike fishing. The improper disposal of old lead acid batteries is a serious threat of lead poisoning to both humans and the environment. After the workshop, the Mountain Village residents collected and shipped out 15,000 pounds of batteries at a cost of \$.32 a pound at their own expense. The village has an ongoing lead acid battery recycling station to insure that lead stays out of their environment.

“As the word of the new 7 Generations course spread, requests from the villages increased a lot. The demand for the 7 Generations course pointed to a serious limitation: there were more requests for the course than I was able to provide. The message of the 7 Generations course fortunately pointed to the solution: train the people in the villages to teach the course. Ownership!

“I have taught over 250 people from more than 110 villages. The majority have taken the ‘Train the Trainer’ course. The desire to learn and spread knowledge is one of the really neat things about working with villages. There are probably over 100 people using the 7 Generations concepts and tools in their villages who have learned it from someone who graduated from the ‘Train the Trainer’ course.

“I do environmental education and technical assistance over the phone now. A village will have identified two or three issues they want to address as a result of doing their Village Environmental Planning Survey. Then they will call me to discuss how they go about addressing the problem. We strategize on issues like getting the whole community involved in the project because the community has to own the solution as well as the problem.”

WHAT NUMBERS CAN TELL US

Do we always have to demonstrate need by measuring the problem directly?

It is sometimes hard to prove a direct connection between an environmental problem and the number of people who might get sick or be affected by it. Sometimes this may be because it takes a long time for the effects of a pollutant to show as numbers of ill people in your community. Sometimes it is because people move away. Sometimes a pollutant can be just one of many things that contribute to an illness. These problems are especially true in small communities where the numbers of people affected may be very small.

We know from many types of studies that lead is a toxic metal. Once it gets into the environment or your body it doesn't go away by itself. It stays around for thousands of years. So the importance of removing lead from your community doesn't have to be demonstrated by the number of deaths or cancer patients. You make the decision to get rid of it for that “seventh generation.”

“When I went to Bethel in 1993 there was almost no lead acid battery recycling. At a recent statewide environmental conference I took a straw poll from the village attendees and I believe that more than 900 tons of lead acid batteries have come out of the villages for recycling.”

- Bill Stokes

“ADEC, as an agency, doesn't fix the problems; the villages themselves fix them. If a village chooses to share their environmental information with us, wonderful! Actually all we need to do is ask. But in providing technical assistance I do get to see most of the numbers in the surveys done by the villages. After discussing it with the village, I either send the information back to the village or destroy it. It is not my information to share.”

- Bill Stokes

Whose numbers are these anyway?

Numbers can be very useful to different types of people. When Bill Stokes designed the 7 Generations Village Environmental Planning Survey (VEPS), he intentionally did not design it as a reporting system to the State of Alaska. Rather, he built it as a reporting system for the village councils. The most important numbers to make a difference in actually correcting the problem were the numbers that the village needed. This data, the process of getting it, and putting the numbers to use were ownership issues. For the numbers to be used, they had to be part of the village's environmental planning survey.

Do you need numbers to tell the whole story about how successful you have been in solving a problem?

Numbers are probably not completely necessary in telling a story but they can be very helpful, even in dressing up a simple anecdote as in this Landfill Snow Birds example of Bill Stokes's experience in Galena:

“At a 7 Generations workshop in Galena in 1998, the attendees wanted to get rid of ‘Landfill Snow Birds,’ those white plastic shopping bags that flutter at the dump and in the village. I showed the class some canvas shopping bags I use at home. The Loudon Tribal Council bought and distributed 6 canvas bags to each house in the village. Since the school children decorated the bags, ownership and use was immediate. Plastic shopping bags were banned from the village stores. The 2002 Galena spring cleanup netted only 2 “landfill snow birds” in the entire village. More than 40 villages have now banned the bag. Extinction is near.”



Aren't numbers and data hard to get because management information systems are very expensive to develop and maintain?

Systems for collecting data are often very expensive to design and even more expensive to maintain and collect data for. But you do not always need to develop your own management information system to have a good source of very useful numbers.

Yutana Barge Lines *Hazardous Materials Hauling* 1999-2001

	<i>Used Oil</i>	<i>Batteries</i>
<i>1999</i>	<i>385 gal</i>	<i>9,100 lbs</i>
<i>2000</i>	<i>9,130 gal</i>	<i>45,960 lbs</i>
<i>2001</i>	<i>3,795 gal</i>	<i>15,240 lbs</i>

Yutana Barge Lines serves villages along the Yukon River. In the past it delivered goods to the villages, but returned to its base in Nenana empty. In 1998 as part of a compliance settlement with ADEC, Yutana agreed to haul hazardous materials from 10 villages along the Yukon for two years instead of paying a fine. Villages had been accumulating hazardous materials like old lead acid batteries, as well as recyclable materials like aluminum cans and used motor oil.

The owner of Yutana was born in the village of St. Mary's, so he was aware of the importance of the service the backhauling was providing. He decided to continue the service free of charge and the service has expanded to twenty villages. All of these villages were familiar with the importance of recycling from 7 Generations.

In the process of hauling hazardous materials out of these villages, Yutana has developed numbers for us to better understand the quantity of hazardous materials in the villages in general. We now know that since 1999 over 70,000 pounds of lead acid batteries and 13,000 gallons of used motor oil have been removed from these few villages.

When looking for numbers to better understand or describe a problem, do some detective work to find organizations or businesses that might have numbers that are helpful.

THINGS TO CONSIDER

When dealing with new problems and new knowledge in your village or neighborhood, you might want to keep in mind ...

- It is your responsibility to protect not only your culture but also your livelihood and the place you live in. You choose. You make decisions. If you don't like it, don't accept it.
- Traditional values are guides to deciding on how to deal with any problem. Traditional techniques should always be carefully considered and evaluated.
- New knowledge and new skills may be necessary to make your community the kind of place you want it to be. Cultures and communities are always changing and subject to outside influences. You have to explore change and decide what the best solution is for you.
- Change is always occurring and you must take ownership of the future in the present. Determine how to make change work better for you and your community.

Almost all of today's environmental issues relate to new materials, new lifestyles and increased population. Communities need to draw both on traditional knowledge and on new information and techniques to deal with new problems. Knowledge increases the ability to control circumstances rather than to be controlled by them.

With the implementation of the Millennium Agreement, Alaska Native village tribal governments have a new and more clearly designed official relationship with the State of Alaska. The State recognizes that Alaska Native villages are sovereign governments, and has entered into government-to-government relationships with federally recognized tribes. This new relationship should improve our ability to solve problems and build healthier communities.

"I always ask my classes to look out the window and to tell me what they see out there that they don't like. Then I ask them to please tell me how they are going to fix it because if they don't fix it, it is going to be there for their grandchildren."

- Bill Stokes

"If you are fortunate enough to spend time with Alaska Native people, remember you are dealing with cultures and traditions that have evolved for at least 12,000 years."

-Alaska Native Health Board

Millennium Agreement Guiding Principles

a) The Tribes have the right to self-governance and self-determination. The Tribes have the right to determine their own political structures and to select their Tribal representatives in accordance with their respective Tribal constitutions, customs, traditions, and laws.

(b) The government-to-government relationships between the State of Alaska and the Tribes shall be predicated on equal dignity, mutual respect, and free and informed consent.

(c) As a matter of courtesy between governments, the State of Alaska and the Tribes agree to inform one another, at the earliest opportunity, of matters or proposed actions that may significantly affect the other.

(d) The parties have the right to determine their own relationships in a spirit of peaceful coexistence, mutual respect, and understanding.

(e) In the exercise of their respective political authority, the parties will respect fundamental human rights and freedoms.

www.gov.state.ak.us/STRT/agree.pdf

When you are visiting a village on State business ...

The following are some practical rules based on guidelines that ADEC has developed to promote better collaborative relationships with villages, especially in the context of the Millennium Agreement. Keep in mind that most of the suggestions apply to any audience, and any community or neighborhood, but these lessons have been learned in the context of work with Alaska Native villages, where some of the expectations are especially important:

- Always have a key contact in the village you are visiting. If you don't already have a contact, you may identify the tribal government key contact for a community by accessing www.gov.state.ak.us/strt/Tribes.html on the Governor's web page.
- Ask your key contact and/or whomever you are going to be working with for permission to come into the village. Ask each time. This allows you to be a guest.
- Show respect for the elders. Make sure to visit with at least one or two elders.
- Always explain why your visit is important. Never use "regulations" as the reason.
- Whenever possible, give presentations as a story.
- Never promise something you cannot deliver. It is okay to say you will try to do something, but don't promise unless you are absolutely sure you can and will do it.
- Slow down your speaking pace. Be respectful in tone. You may be talking with people for whom English is a second language. Speaking slowly also gives people a chance to think. This is especially important for a new and different subject.
- Pause occasionally—more often than you may be used to. Let people respond at their own pace.
- Listen carefully. Don't focus your attention on your next response to a statement. Talk and listen with your heart as well as your head.
- Give presentations in school. Be a conduit for other information or contacts.
- Become a resource to the community.
- Get the community involved as a constructive partner in solving their problem.
- Prior to the village visit, contact the school principal and/or science teacher. Offer to do a presentation about why you are in their village. Children will take messages home to parents. Elders will know about you. Give children ownership by teaching the skills that they will use as future leaders of the community.
- Bring food—a box of fresh fruit for the Head Start program or the elders.
- Walk around the village. Make an effort to stay a couple of days. Get to know the people informally. Let them know that you are interested in them and their community.

When Doing Research with Native Communities and Tribal Organizations ...

Another longstanding grievance of Alaska Natives relates to “invading” government agencies and academic institutions doing research in Native communities, not sharing the credit for or results of research conducted and not sharing the benefits of research findings. The Alaska Native Health Board, in collaboration with the American Indian Law Center in Albuquerque, New Mexico, has produced *Guidelines for Partnering for Native and Tribal Organizations on Research Studies*. This guide promotes a respectful “win-win” approach by providing “advice and guidance for communicating with, obtaining consent from and including communities as partners in research projects. It is designed to benefit the institution, the researcher and Alaska Natives and to develop and maintain a cooperative working relationship among all involved. It is written to include community Native involvement in all phases of a project including developing, planning, implementing, analyzing and interpreting results.

TO FIND OUT MORE

Department of Environmental Conservation
Environmental Assistance Center
1 (800) 510-ADEC (in Alaska)
(907) 269-7586 (outside Alaska)
CompAsst@envircon.state.ak.us
www.state.ak.us/dec/dsps/compasst/cap.htm

Alaska Native Health Board
Partnership Guidelines & Other Publications
www.anhb.org/sub/epi/publications.html

“Communicating Across Cultures”
Video Tape Presentations by Father Michael Oleksa
Publisher: KTOO Television, Juneau: info@ktoo.org
Alaska State Library, Circulating Collection
HM258.C65 1994 Vol.

Office of the Governor
State Tribal Relations Team
P.O. Box 110001
Juneau, AK 99811-0001
(907) 465-3500
www.gov.state.ak.us/strt/

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 6. Educational and Community-Based Programs
Chapter 11. Environmental Health
Chapter 12. Food Safety
Chapter 26. Public Health Infrastructure

Customs and Courtesies in Alaska

Traditions and customs vary dramatically but there are a few general rules that are universal.

Respect for elders: Elders are ... the guardians of tradition and culture. If you are lucky, some will participate in your project.

Communication: It is a serious breach of manners to interrupt anyone who is talking. Community meetings are forums for all to speak and to say whatever is on their mind.

Time: A scheduled one or two hour meeting is also a breach of local custom. At a minimum plan on several days in the community with several open ended meetings.

-Excerpt, ANHB Guidelines

NOTES

FAMILY SPIRIT GATHERING

STRENGTHENING INDIVIDUALS, FAMILIES AND COMMUNITIES

"At the beginning of the Family Spirit Gathering, Elder Peter Jacobs Sr., knowing DFYS's reputation to take away kids, asked the white DFYS worker to join him in the middle of the gym. He then thanked him for coming to help with family matters involving children and gave him a big hug."

-Patrick Frank

This is the story of how Yup'ik and Cup'ik villages are collaborating with regional, state and federal agencies to build healthier communities. The collaboration combines the traditional and non-traditional techniques of treatment and care supported by both local and non-local resources. The village plays the central role in allowing a program into the village as well as determining and managing the joint strategy. The story is based on the written history of the first Family Spirit Gathering in Kongiganak and on the generous input and assistance of Julia Kanuk, the Family Spirit Project Coordinator at the Yukon Kuskokwim Health Corporation in Bethel.

The Origin of the of the Family Spirit Gathering

In 1997 the State of Alaska's Division of Family and Youth Services (DFYS) contacted the Yukon Kuskokwim Health Corporation (YKHC) to help develop an approach to better deal with concerns about possible child neglect or abuse in the home. They wanted to put an end to removing village children from their families because of threats caused by alcohol abuse, domestic violence and other family problems. Together they decided on a strategy of bringing the family in crisis to a fish camp setting for "culturally relevant" counseling and other supportive services. They felt that this approach had been effective in other Native American communities and could help in the villages selected.

YKHC and DFYS then took their ideas to the Traditional Council of the Village of Kongiganak to seek advice and request permission to introduce this program in the village. An elder at the meeting advised them that the program would not work because it would only stigmatize the family. It would compound, not solve, the problem. The elder went on to explain that these are complex problems that belong to the community as well as to the individual and the family. He stressed that it is the responsibility of the village to help address and solve them.

With village guidance and advice, a new Family Spirit Gathering program was designed for full community participation. The YKHC's Family Spirit Project helped organize what it called a Village Wellness Team from people with a lifetime stake in the community, with special knowledge and with a commitment to make the gathering a success. It included two Kongiganak Tribal Council members, an Elder, Village Alcohol Education Counselor, Village Public Safety Officer, Community Health Aide, Community Health Aide Practitioner, Child Care Provider and a Community Health Representative. The Team's purpose was to assure that the Family Spirit Gathering addressed the village's needs in a way that would work and also meet the concerns of DFYS and YKHC. The community's Village Wellness Team, in collaboration with Tundra Women's Coalition, The Association of Village Council Presidents, Orutsarmuit Native Council, YKHC and DFYS, developed a Vision Statement and identified results they wanted from the Family Spirit Gathering in the form of expectations.

The Village Wellness Team selected a dozen training facilitators to help run the gathering and broaden involvement and community ownership. The entire team spent several days of training in Bethel to



The Gathering's Expectations

- *Children will have safer homes*
- *Safer and happier families*
- *Fewer reports of harm to children*
- *Better communication among participating families*
- *Learn basic conflict resolution skills*
- *More involvement of family activities with participating families*
- *Parents have better access to substance abuse, mental health and social services*

increase their skills and add to their wealth of knowledge. The training sessions included anger management, alternatives to violence, conflict resolution, peer mediation, positive Yup'ik parenting, grief and healing, domestic violence, positive discipline and child development. Finally, the Village Wellness Team identified local and outside presenters to address the problems identified by the team. All of these efforts were designed to make the gathering a success.

THE FIRST FAMILY SPIRIT GATHERING

Day One

On the first of June 1999, after two years of planning and preparation, the first Family Spirit Gathering was held. The first day focused on sharing parenting values through personal and traditional stories. The Charlie Paukan family shared what they learned about their struggles with alcohol, about asking for forgiveness, offering help and drawing strength and assistance from their children and the Creator.

In the afternoon Pat Frank, one of the facilitators from outside Kongiganak, shared his story, which he called *The Quiet Duck*. The story was recorded during the gathering:

“From the beginning of time, Alaska Natives have been able to observe and listen to the whisperings of the Chief Spirit, heard in Mother Nature. Messages of peace, harmony and abundance flow continuously to all mankind if only we take the time to be still, aware and clear.

“Last summer while driving north on Lake Otis Parkway, I saw a female mallard duck, with closed eyes, cat-napping in the middle of a five-foot median. The brown duck looked so out of place as the noisy noon hour traffic surrounded her.

“Even more peculiar was my sighting of a cow moose the very next day at the same location. This time I slowed down while the adult moose, with lowered head, rambled through the heavy traffic. ‘Why did I witness these scenes?’ I wondered. It seemed that because I did not pay attention on the first day, a more distinct reminder loomed before me.

“Three weeks before seeing the duck, I was engrossed in several intense, consecutive workshops. The pictures flashing in my mind were similar to the racing traffic. I desperately needed to stop and sit quietly like the motherly mallard. Quietness restores peacefulness and restores perception. I have learned that my thoughts match reality in my life. Inner turmoil adds to life’s problems, while inner peace makes things flow smoothly.

“I have been reminded by several of my spiritual advisors to go to nature for meditation and prayer when agitated. But I so easily become entangled in the turbulence of trying to make things ‘happen.’

“How quickly I had forgotten to be still and ask for help and trust that my Creator will respond. I needed to take a few minutes each day, to remember that the seeds of tranquility inside will germinate into calmness on the outside.

“Even though both the duck and the moose were entwined in snarling city traffic, each one was poised and peaceful. Only now do I realize that my thoughts, my state of mind, condemn me or free me.

“Oh, freedom of choice in life ... I now choose peace.”

The gathering ate dinner together and by the end of the day men returning from hunting joined the group. More than 50 Kongiganak adults and 40 children attended the opening day. Visiting elders and Family Spirit Gathering guests were invited to take a steam. People sat together through the evening discussing and sharing their feelings about the day.

Day Two

The second day addressed Yuuyaraq, the Way of Life. Elders and members of the Tundra Women’s Coalition talked about raising children who have experienced trauma and abuse and small group discussions followed. The afternoon was filled with stories, and a talking circle of young and old discussing old and new ways of family life.

Day Three

On the third day the gathering shifted its focus to communication within the family. Presenters from The Association of Village Council Presidents, the State’s Division of Family and Youth Services and YKHC talked about the Indian Child Welfare Act, alcohol issues and child protection. Members of the gathering shared their personal ideas and thoughts through an open mike. In the afternoon the gathering divided into two talking circles, one for men and one for women. Thoughts from the talking circles were later shared with the whole gathering. Teaching and discussions continued.

Day Four

On the morning of the final day, presenter Mary Stachelrodt of Bethel gave a talk and led a discussion of the *Ellam-iinga* (pronounced “klum eengah”), the Eye of Awareness. The Eye is a traditional model of the physical, emotional, mental and spiritual aspects of experience. It helps you to see where you are blocked. Closing the Eye of Awareness can blind or cause a narrow view of the world and hinder positive growth. Opening the Eye of Awareness restores the relationship among the physical, emotional, mental and spiritual. When the eye is open the circle is made whole again.

In the afternoon, the people of Kongiganak and their guests discussed the meaning of the gathering for them. They talked about what had happened, the best experiences, the lessons learned, the important Yup’ik and Cup’ik values shared, recommendations to the community wellness team about what topics they would like to discuss at their next gathering and the ways that they can help each other in times of need.

“Our children need to learn to listen about what is good, through well meaning words, such as those through our ancestors’ stories.”

*-Peter Jacobs Sr.
Bethel Elder*

“It does take a village to raise a child.”

*-Julia Kanuk, Coordinator
Family Spirit Project*

“Just because you are married, you aren’t separate from other families.”

-Open Mike Comment

“There comes a time when you have to take a risk and talk about the pain. If you don’t talk about it, the pain comes out as rage, violence or grief. When the heart is broken, the Eye is slammed shut. When you let the pain out, the heart starts to heal.”

*-Mary Stachelrodt
Kongiganak, 1999*

"Ellam-iinga is a Yup'ik word that means eye of the universe, eye of awareness or eye of God. Many old Yup'ik artifacts have the circle and dot motif which signifies God and man. Ella is the root word meaning the universe, all that is, weather or awareness.

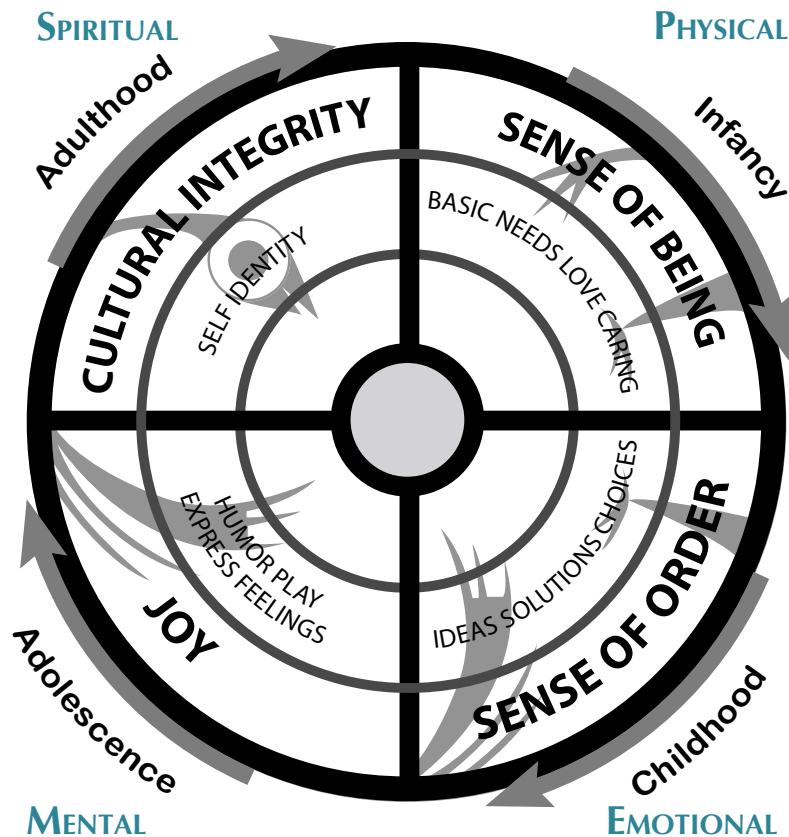
"My father and mother, Nicholas and Elena Charles, helped me understand the relationship between Ellam-iinga and the healing model I had been playing with when I was studying to be a counselor in the early years of my recovery. I was so excited. I had large sheets of paper and started drawing and asking my parents about the significance of eye of awareness and it all fit. It was really important to me that it had a cultural base.

"This model is very personal. The stylized raven was designed for me by my brother George Charles as part of a drum in 1986. I integrated the raven and drum into my model of the Eye of Awareness. The Raven in Yup'ik represents the Creator and a trickster and is also integrated here as an embryo in an egg.

"The red and blue are Nelson Island colors. My father is from Nelson Island. The blue is made from a mineral there and the red comes from the mountain. It is said that Raven had a daughter and that the red color came from her menses."

-Mary Stachelrodt

ELLAM-IINGA, THE EYE OF AWARENESS



Mary Stachelrodt explains concept and recalls the Family Spirit Gathering in Kongiganak:

"Yup'ik, Cup'ik, Inupiat and other Native Americans share a similar concept of *Ellam-iinga*, the Eye of Awareness. The root word, *Ella*, means awareness or the universe with the weather and everything around it. When you add *iinga*, it means eye of the universe or the eye of awareness or the eye of god. *Ellangeq* is such an important concept because it also means to wake up, to 'sober up your mind,' to 'come clean with things,' to become more open. It sees the universe from the perspective of the individual: mental, spiritual, physical, the weather, the stars and everything.

"We are using it a lot more now. It is as if it had been asleep for a while. Things go to sleep for a while and then they wake up. It is like a sleeping giant. Now it is awake and in the light again. For a while it was sleeping because people hadn't been paying attention to it much.

"The model incorporates my own personal experience as well as what I have learned from other recovering people. It is a dynamic model, expanding and growing just as our own human development. If given positive support, the process of human development grows in a predictable

and natural manner resulting in a healthy and productive human being. If the process is interrupted or ‘blocked,’ unnatural responses and destructive behavior emerge. The model is a simple and understandable way to begin to re-awaken the sleeping awareness in all of us. We are blessed naturally with the desire for love, understanding, a feeling of well being and a desire for positive change.

“The response was good in Kongiganak and people were able to recognize that they were going through a healing process and they were remembering that they had it within them to heal. It reminded them. Because this is a model with a foundation in traditional Yup’ik values and concepts, it was very understandable.”

After the Gathering

The Family Spirit Gathering in Kongiganak was a success. Not only was “work done” on problems, but also each day had feasts and opportunities to share laughter. Guests from neighboring communities were invited to observe, eat and take steams. By the fall of 2002 the villages of Napakiak, Tuluksak Emmonak, Tuntutuliak, Nunam Iqua (pronounced “new num ikwa” and formerly known as Sheldon Point), Mountain Village, and Hooper Bay had held Family Spirit Gatherings.

The Family Spirit Gathering Project has helped communities develop a new way to handle a wide range of problems. The villages call it the “mini-conference.” They initiate it and control it. YKHC’s Family Spirit Project and Village Services Department are available to teach how to coordinate and access local and regional resources for speakers and door prizes. Julia Kanuk, Family Spirit Project Coordinator, explains:

“The whole community gets involved and they invite surrounding villages. Young people and old participate. It seems like the people want to build a more positive community. They want to start bonding, creating relationships.

“Each year more people are using these mini-conferences to deal with issues that family spirit gatherings did not cover like grief, death and dying, how youth and elders should get along, how to keep the children in school, and teen pregnancy. And they have so many traumas happening and new problems. In one village a person shot a mother and child and then shot himself. That had never happened before. In another village a boy accidentally shot his sister. They had never dealt with anything like that. In dealing with these traumas they find these mini-conferences very helpful.

“People are getting a lot more aware that it’s OK to talk. It’s OK to feel. It’s OK to cry. These are not hidden agendas any more. They are waking up and are more aware that they don’t have something keeping them from community and personal growth. They want to see their future generations get the best out of their lives and want to help their community and help themselves.”

Quinhaqak (pronounced “kwin a hawk”), Kalskag and Kwethluk are preparing to hold their first Family Spirit Gatherings in 2003.

“Some people are in denial and some people are afraid to participate. Gradually things appear to loosen up and more participate. A month later, the people review what happened to identify needs—workshops, speakers, other topics, services—that may help in the future. A publication is then produced summarizing and documenting the experience.”

*-Julia Kanuk, Coordinator
Family Spirit Project*

WHAT NUMBERS CAN TELL US

In guiding the design of the Family Spirit Gathering, the Kongiganak Elder advised that the problem of the individual family belonged to the whole community. The problem belonged to the whole community and one family's crisis was one of possibly many symptoms or indicators that the community is "out of balance."

To help understand the effect of the Family Spirit Gatherings and subsequent mini-conferences, Kongiganak, YKHC and DFYS have chosen to track the number of "reports of harm." The safety of children is a core concern of everyone involved. The number of reports of harm to children can provide a clue to whether positive progress is being made or not. But such numbers must be used with caution because they may not reflect the true incidence, especially if there are different ideas of what should be reported, or hesitance to report.

Annual Reports of Harm in Kongiganak

FY 1999	FY 2000	FY 2001	FY 2002
66	42	29	19

The reports of harm in Kongiganak since the first Family Spirit Gathering have declined. Fewer reports of harm are being made every year. Is this because there are fewer actual incidents of harm? Or could it be because people are less likely to report incidents because they are more aware of the consequences or because they have other ways of dealing with cases of abuse? Is something else happening to affect the reports of harm? We can't tell by the numbers alone. We can't even be sure by looking at the numbers that the Family Spirit Gathering and mini-conferences are having any effect at all. But the numbers do suggest some progress.

In another community that had a Family Spirit Gathering, the numbers of reports of harm are quite different. Is this community doing better or worse since the Family Spirit Gathering? Maybe more people are aware of the problem so there are more reports of harm. Maybe the community as a whole was becoming healthier but only one or two families were having serious problems. In small communities sometimes one or two people or families can make a big difference in the way the numbers look. And you have to keep in mind that these are only reports of harm, not necessarily actual cases of harm.

Annual Reports of Harm in Another Community

FY 1999	FY 2000	FY 2001	FY 2002
56	111	60	61

In order to get a better idea of what exactly is happening, it would be helpful to get first hand reports from the community itself. This could be done by formal interviews with community members, especially with people in a position to understand the general situation: elders, counselors, or community leaders. Regular site visits from someone like YKHC's Family Spirit Project Coordinator are another way to get information to help interpret the numbers, in the context of familiarity with the community.

A similar approach would be to hold "focus groups" in which seven to ten people from the community would get together to discuss the effectiveness of the Family Spirit Gathering, including issues of domestic violence and reports of harm to children. As in a talking circle, the atmosphere of a focus group should be safe and inclusive with room for all participants to share their ideas and insights. The results of this type of discussion can be very helpful in knowing how best to interpret the Kongiganak data, for example. The focus group might also give us a better understanding of whether the community as a whole was becoming more or less healthy as a result of the mini-conferences or for some other reason.

In bigger communities, especially cities, a scientifically designed and administered questionnaire might also improve our ability to interpret a trend in the numbers of reports of harm and related issues such as arrests, substance abuse hospital admissions, suicide attempts, the percent of children succeeding in school, etc. Neighborhood or community associations, councils or agencies can organize to accomplish any part or whole of understanding needs, meeting together to strengthen community, or evaluating the success of efforts they may have undertaken, such as the Family Spirit Gatherings.

THINGS TO CONSIDER

A Family Spirit Gathering can be a powerful tool for helping small communities or neighborhoods deal with widespread problems, especially issues like personal, family, cultural or community trauma, intergenerational grief, substance abuse, child protection and parenting issues. It may not be for every community. That is for the community to decide. In recording their Family Spirit Gathering, the people of Kongiganak thought that the following were important ideas to keep in mind.

Things you can do to help families or individuals in recovery:

- “say something nice to them and pray for them”
- “watch their children so that they can go to treatment”
- “clean their house when they are away in treatment”
- “send them letters encouraging them while they are in treatment”
- “call them when they are in treatment (but not during the first two weeks)”
- “meet them at the plane when they come home”
- “make a banner from the community congratulating them”
- “bring them fish and berries when they return”
- “be there for them if they have a relapse”
- “hold a potlatch for them when they return home from treatment”
- “visit them”
- “invite them over for dinner or tea”
- “take them hunting with you”
- “take them to church with you”
- “forgive them for things they did when they were drinking”
- “hold a potluck for them”
- “invite them to have a steam”
- “start an A.A. group”
- “set an example”

Yup’ik/Cup’ik Values

Hard Work
Humor
Humility
Cooperation
Family Roles
Hunter Success
Knowledge of Family Tree
Knowledge of Language
Respect for Nature & Animals
Respect for Elders
Knowledge of Yup’ik Names
Sharing
Respect for Tribe
Respect for Others

"The best part of the Family Spirit Gathering was getting together and sharing the problems and knowing that we are not alone."

Some general reminders from the people of Kongiganak:

- "the Elders prepare a path for us"
- "talk to children in the morning"
- "respect children's feelings"
- "sharing feelings lightens the load"
- "be a role model to our children"
- "continue traditional teaching of values"
- "love is the key to our spiritual healing"
- "forgive yourself"
- "encourage young men and ladies to start visiting relatives in jail"
- "in order to change, you have to take risks"
- "only you know what works best for your community"
- "answers come from the community itself"
- "traditional teachings are our sacred way, the way to be human"
- "have a talking circle"
- "in this world we can live well and full if living in a good way"

TO FIND OUT MORE

Alaska Department of Health and Social Services
Division of Family and Youth Services
www.hss.state.ak.us/dfys/default.htm
www.hss.state.ak.us/dfys/Links/default.htm
(907) 465-3191

Yukon Kuskokwim Health Corporation
Family Spirit Project
1 (800) 478-3321

National Indian Child Welfare Association
www.nicwa.org/

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 4. Substance Abuse
Chapter 5. Mental Health
Chapter 6. Educational and Community-Based Programs
Chapter 7. Health Communication
Chapter 8. Injury Prevention
Chapter 9. Violence and Abuse
Chapter 26. Public Health Infrastructure

EASING THE END OF LIFE JOURNEY

HELPING HANDS IN BRISTOL BAY

*"It is better for elders to be taken care of at home than to be sent away."
-Helping Hands Program*

People in rural areas in Alaska often have difficulty finding specialty medical services. Lack of human and financial resources mean that services available in urban areas need to be re-created in ways that work for sparsely populated areas. The Bristol Bay Area Health Corporation saw a need for hospice-like services to residents with chronic and terminal illnesses, but did not have the resources to adopt urban hospice programs. Instead, they designed a program that built on the strength of their community—caring people. The new program uses volunteers and existing medical resources in new ways.

In creating this new end of life care program, Bristol Bay Area Health Corporation tailored services and program materials to meet the cultural needs of area residents. Not only were materials developed in Yup'ik, with Yup'ik artwork, but the volunteer program itself strengthens Yup'ik culture by providing a place where elders can communicate their wisdom and life experiences to young people.

Alex's Story

By Helping Hands Program, BBAHC

Alex, a Yup'ik Eskimo, lived in the small village of Ekwok, Alaska, where he spent his life fishing, hunting, and raising his family. Now he was at the end of his life. Alex was bedridden and spoke very little. He was in Kanakanak Hospital, and his wife, Anecia, had to fly to Dillingham to visit him. Once she knew Alex wasn't going to get better, Anecia decided that she wanted to take care of him at home near his family and friends. She didn't want him to stay in the hospital.

A hospital bed and other essentials were loaded into a small plane and flown to Ekwok. Personal Care Attendants (PCAs) that live in the village helped care for him. Weekly visits by a home health nurse, and regular phone calls supplemented his care. A physician visited Alex during scheduled village trips every few months. The primary treatment goal was to make him comfortable and pain-free.

At one point, Anecia grew tired of caring for Alex 24 hours a day. She wanted to go to a nearby village for a Russian Orthodox festival. Respite care was arranged. Alex would be flown to Dillingham's Kanakanak Hospital for a few days. As soon as Anecia learned it was possible for her to have a break, it was all she needed—she decided she preferred to stay home with Alex.

Kristy, Alex's nurse, visited the household regularly. Rituals were established. She had a cup of tea with Anecia, and then examined Alex and changed his dressings. Then she left the room and came back with two jellybeans.

"Okay Alex, we've finished our work," Kristy said and gave Alex a jellybean and popped one in her mouth.

Ikavurtem Unatai



Helping Hands Program

*Easing the end-of-life journey
with care, comfort and choices*

*The logo—a mask with soft
extended hands superimposing
over a typical southwest Alaska
scene—shows many things.*

The Mask

*Masks are a common part
of Alaska Native culture.
Traditionally, shamans (medicine
men) wore them during healing
ceremonies, honoring the spirits.
The ceremonies were used to
ask for guidance from the spirits.
Masks were also worn during
celebrations to honor an animal,
tell a story, or show a vision.*

*In this mask, one eye is open,
one eye is closed—depicting
the end of one journey and the
beginning of another journey.
Extended out from the mask are
hands, the helper's hands, the
heart of BBAHC's program.*

The Background

*Winding rivers are common
throughout rural Alaska and
meander through mountains and
the tundra. They connect villages,
and are a major pathways of
travel. In addition, they carry
salmon and other fish, an integral
part of the Alaska Native lifestyle.*

*Alaska Native elders who know
that death is near may talk about
their "journey" and ask, "Who will
cross the river with me?"*

*The Helping Hands Program will
help the people complete their
journey across the river.*

Alex died at home on November 6, 1999. He was 86 years old. "I woke up at 6 AM and he seemed a little cool, so I put another blanket on him, and turned up the heat. At 8 am, I woke up again. It was very quiet. He wasn't breathing," his daughter Mollie said.

The men of the village built a simple wooden casket and painted it gray-blue. The whole village turned out for the funeral. It was a cold, clear day. When Kristy arrived, she went to the room in the school reserved for the family. She gave Anecia a hug.

"You took such good care of Alex," Kristy told her.

A Russian Orthodox funeral was held for Alex. After the service, each person viewed Alex and kissed him. Sons and brothers carried him to the gravesite. Alex's eleven-year-old grandson sang Amazing Grace, his young clear voice ringing out in the silent, cold winter air. As he sang, the men in Alex's family handed around a hammer. Each of them hammered a nail into the top of the casket. Ropes were placed around the casket and the men guided it into the ground. School was closed for the funeral, and afterwards, everyone met at the school to eat.

As part of the Helping Hands Program follow-up care, Kristy visited Anecia a few weeks later. "I'm doing okay," Anecia said. "I'm lonely, he had such a presence." "He died a good death," Kristy told her. "He died the way he wanted to—at home with no pain. He died gently."

In the following story, former and current employees of the Bristol Bay Area Health Corporation discuss the development of the Helping Hands Program.

Helping Hands: Easing the End of Life Journey*

By Christine A. DeCourtney, Kristina Jones & Nina Heavener

Only sixty years ago, Alaska Native elders died at home, surrounded by family and friends, in the small villages where they had lived most of their lives. Western health care shifted the location of dying from the familiarity and comfort of home to distant hospitals and nursing homes. Until recently, terminally ill elders in Bristol Bay often spent the last part of their lives in unfamiliar surroundings. Many died alone, without the emotional support of family and friends. Family and friends who live in the village were denied an opportunity to share in the elder's wisdom and knowledge and to participate in cultural practices surrounding end of life. Grief was compounded and complicated for survivors who had not been present for the death of a friend or relative.

As the numbers of elders increased in the Bristol Bay area, more area residents were being sent to Anchorage for health care that was focused on treatment and intensive care, rather than on comfort and symptom relief. One village resident kept her mother at home during her last year of life. She got little advice and help, as the hospital in Dillingham was not geared to provide this kind of care. A nurse employed by the Bristol Bay Area Health Corporation (BBAHC) saw the same need for appropriate end of life care. Together with another BBAHC employee, in 1994, they developed a

*Helping Hands: Establishing a Culturally Sensitive End of Life Care Program in Bristol Bay, Christine A. DeCourtney, Jones, Kristina, Heavener, Nina (submitted for publication)

program and sought funding. The proposal was approved, but not funded twice before it was funded by the Robert Wood Johnson Foundation.

The Helping Hands program supports the wish of the Native people of Bristol Bay. They want to be in a familiar setting, close to family and friends in their final days. Helping Hands helps patients and their families find comfort and care in those last days, within their own culture, among their friends and family, with familiar foods and Native medicines.

Program Design

Bristol Bay residents who have multiple chronic or a terminal illness are eligible for Helping Hands. The program design identifies a primary caregiver for each patient, trains village-based workers, and develops trained volunteers in each village. A home health nurse visits each patient on a regular basis and provides telephone support between visits. Patient care plans draw on basic village resources. The focus of the program is pain and symptom control, combined with training for family, health care providers and volunteers. The program was not designed to make a profit. It was developed with the belief that providing at-home care during the last part of life, and avoiding expensive medical evacuations and hospital stays, could reduce overall health care costs while improving quality of life and family experience.

The development of culturally sensitive program materials is an important part of the program's design. BBAHC had previously experienced a lack of success when trying to use mainstream program materials in a tobacco use cessation program. A literature review revealed little material that addressed end-of-life issues in American Indian/Alaska Native or in rural populations.

Focus groups with elders from the three Native cultures in Bristol Bay were held to aid in actual program design and materials development. Village tribal councils and village senior services were notified about meetings and their support requested. BBAHC staff and a medical anthropologist facilitated the focus groups. Focus group findings provided key information

that was incorporated into program materials and design. Some program materials were translated into Yup'ik and recorded on an audiocassette to help non-English speaking village elders understand the proposed program.

Elders provided valuable information and perspectives regarding needs and traditional practices around death. It was important for focus group facilitators to remain in the village overnight to provide opportunity for additional one-on-one sharing. Some of the most valuable information critical for successful program design was not revealed during the focus group but later in the day or evening. For instance, elders had difficulty understanding why their grandchildren, who had received training and worked as Personal Care Attendants (PCA), were "paid" to take care of them. Also, elders were ashamed when "outsiders" took care of them instead of family. This information was incorporated by BBAHC into a written story for villagers that discussed how times have changed in the village. The story uses the example of schools where paid teachers provide education as opposed to elders who were the only teachers many years ago.

Volunteers are important to Helping Hands. The volunteer program recruited village youth as well as adults. Approximately 10 villages have teen peer groups, called Peer Helpers. This prevention program, funded by the State of Alaska, is designed to help teens avoid substance abuse and suicide. The Peer Helpers receive training from the Helping Hands program volunteer coordinator in order to provide support to terminally ill elders. Teen volunteers help with chores and respite care. Another important function of the teen volunteers is the recording of traditional knowledge and experience into the journal each patient receives. This is especially important since many elders do not write, but are willing to share life experiences orally. In villages without Peer Helper programs, individual village youths are recruited as volunteers.

As program design progressed, it became evident that the Helping Hands program would never be able to meet existing state and federal

rules and regulations regarding hospices. One limitation was the requirement for nurses to be able to reach a patient within one hour, virtually impossible in most of the region. The initial concept of seeking Medicare certification was abandoned. Quality of life, pain and symptom control, reduction in costly medical evacuations and hospital stays, and the opportunity to involve family and friends in a traditionally important part of Native culture became the focus of the program.

Program Implementation

Implementation of the program took much longer than anticipated. Staff turnover added delays. The reality of living in remote communities, the need for constant and perilous travel on small planes, and the challenges of coordinating medical care with limited resources were problematic. Focus groups were cancelled and rescheduled due to weather and village cultural and religious observances.

Far more patients than anticipated became Helping Hands patients as the word spread about the program. Elders who had moved to Anchorage to get health care services for chronic and other medical problems moved back to their villages. Physicians at Anchorage and Dillingham hospitals allowed patients to go home because the Helping Hands Program could provide care for them at the end of life. Back in their home surroundings, many patients thrived and survived much longer than the prescribed “six months to death” medical pronouncement.

Unexpected problems surfaced. For example, the subsistence lifestyle that requires villagers to leave their homes in summer and travel to fish camps created problems of caring for infirm and frail elders left behind. Occasionally, patients returned to the village without the Helping Hands Program staff knowing about their return.

In response to what BBAHC learned, the Helping Hands Program was redesigned as part of the health corporation’s home health program to better address the longer than expected life of patients who returned to their home village. Care plans were developed around patient goals and the realities of a subsistence lifestyle.

For instance, berry picking was encouraged to promote healthy eating and exercise for patients with diabetes. Personal care attendants now visit more often when families are away fishing and hunting. Program staff work to make sure volunteers are available to provide meals and other needs when caregivers are involved in subsistence activities.

Program implementation called for extensive training of the region’s more than 80 Community Health Aides in care for comfort and symptom relief and in caring for elders nearing the end of life in the village. Family caregivers were eager for information that helped them understand what was happening to their loved one. The BBAHC home health nurse for the Helping Hands patients was able to respond to concerns by telephone and during village visits. As a result, emergency flights to Dillingham for physician visits declined for Helping Hands patients.

Since the program began in 1999, the percentage of home deaths for selected causes has changed from 33 percent in 1997 to 77 percent in 2001. The number of people dying at home with friends and family has more than doubled. Helping Hands has shown that end of life care can be combined with traditional customs in a cost effective and culturally responsive program. Elders in remote villages can remain at home, in familiar surroundings, as the end of life nears, and can pass along their wisdom and knowledge to the young people in the community.



Some Helping Hands Materials for Bristol Bay Residents

Mainstream American palliative care materials, particularly those designed for the general public, did not meet the needs of Alaska Native elders who could not relate to the depiction of home life, people and activities of daily living in the mainstream materials. A number of items were developed to aid in the understanding and acceptance of the *Helping Hands Program*:

- **Program brochure**, describes the program and how it integrates traditional ways and contemporary medicine.
- **Volunteer brochure**, explains why volunteers are important as someone nears the end of life and what the reader can do to help. It describes customary and traditional ways of helping such as bringing in firewood, smoking fish, and picking berries.
- ***Who Will Cross the River with Me? A storybook*** – As Native elders in Bristol Bay near the end of life, they often talk about crossing a river. The book incorporates findings from focus groups to describe a situation in which an elder is able to remain at home at the end of life. It incorporates a number of nuances of life in the village that are important to remember when an outsider comes into the village, e.g., always remove shoes at the door, sit down to have tea and talk, examine a patient in the presence of family and friends. The book is narrated in English and Yup'ik by a Yup'ik storyteller and linguist and available on an audiocassette. While there are three main Alaska Native groups in the Bristol Bay area, the predominate Native group is Yup'ik Eskimo which also has the largest number of non-English speaking elders.
- **Journal** – “When you are caring for someone who is dying, you don’t have time to record his/her memories or stories or those of friends,” said a local nurse and a recent widow. The journal includes relevant prayers and poems, primarily Native American. There are sections for “Friends’ Thoughts” with memory reminders, such as, “One of my favorite conversations with you ...” and “When I eat__

I think of you ...” Another section is for the patient with headings such as, “What I want people to remember me most for is ...” and “What I will miss most is ...” The journals also include a place for a family tree. Since many of the elders were orphans (parents died during the Spanish Influenza epidemic) their families have a chance to gather history for younger generations. In one instance, a nurse took her husband along to visit a patient. The patient had grown up in the orphanage with the nurse’s husband’s father and was able to recount stories of his life as a young person.

Early results have shown that the journals are being used in a number of ways. Family and friends have filled some journals with memories. Others include elder stories recorded by visitors and teen volunteers. Some remain open in the Dillingham assisted living facility for people to write in as they wish. One of the early recipients was dubious of the value of the journal and skeptically paged through it. Suddenly he started telling a story of his youth and began smiling and laughing. It was the first time he had laughed in a long time.

The journals are very popular outside the program and have broader relevancy than anticipated. Proceeds from the sale of journals help in a small way to offset the costs of continuing the Helping Hands Program.

- **Caregiver, volunteer, CHA/P guides** – Loose-leaf notebooks provide information on how to care for patients nearing the end of life. While they contain many of the same materials mainstream guides include, traditional knowledge and wisdom sections are also included, as well as practical information that addresses caring for patients in a remote setting. The community health aide guide duplicates portions of the guide aides use to provide care as well as additional information. The caregiver guide includes a special first page “How to take care of ____.” The patient’s name is written on the page as well as contact telephone numbers for nurses and the volunteer coordinator. A section on Native plants and medicines is also included in the guides.

WHAT NUMBERS CAN TELL US

Aging in Alaska

Alaska is first in the nation in the proportional growth of our senior population—with a 50 percent increase in people aged 65 years and older between 1990 and 1999. The number of Alaskans over 65 is expected to increase to over 90,000 by 2018, nearly triple the 2000 count. (*Alaska Population Overview: 1999 Estimates*, Alaska Department of Labor and Workforce Development).

Infectious diseases and injuries were major causes of death in 20th century Alaska. As life expectancy increased and the population aged, chronic diseases like cancer and heart disease have become the leading causes of death. More Alaskans will need care for these illnesses, and many will eventually be seeking end-of-life care in their own villages and communities. Rural areas will be challenged to provide services for their aging populations.

Programs like Helping Hands can measure success in terms of their goals. For example, Helping Hands gives results in meeting its goal of allowing more elders to be at home instead of in an institution at the end of life: “Since the program began in 1999, the percentage of home deaths for selected causes has changed from 33 percent in 1997 to 77 percent in 2001.”

THINGS TO CONSIDER

Is a program like Helping Hands something you need in your community?

Many Alaskans will need end of life care, care that provides comfort and pain relief during a terminal illness. Larger Alaskan communities have hospice programs funded through health insurance or Medicaid/Medicare. Hospices require specialists and other expensive resources not available in rural areas. Throughout rural Alaska, elders and others approaching the end of life have been sent to hospitals or nursing homes in urban areas for care, depriving them of familiar environments and the support of family and friends. Bristol Bay Area Health Corporation (BBAHC) recognized that home care in the village was more sensitive to

individual needs. When end of life care is provided in the village, the number of distressing and expensive medical evacuations by air can be reduced.

What are some of the challenges in setting up a program like Helping Hands?

Family members, health care providers, and volunteers must be trained in end of life care to create a program like Helping Hands. Many younger people in the community, and many members of the boarding school generations, had never cared for an elder dying at home before. Many health care providers had had little experience with end of life care.

Financing village-based end of life care programs is difficult. Such services are not reimbursed by insurers and Medicare. In order to assure funding for a nurse coordinator and a volunteer coordinator, Bristol Bay Area Health Corporation put Helping Hands in their Home Health Program, which is Medicare reimbursable. In general, funding agencies may not be flexible enough to pay for innovative programs. Efforts are needed to change Medicare/Medicaid regulations make end of life care reimbursable.

What are some of the strengths of the Helping Hands program?

BBAHC worked hard with residents to make sure the program met their needs in ways that supported their cultural values. From program design to challenges along the way, the residents’ needs and values were the top priority.

Development of the journal to record stories and memories provided a forum for elders to pass on traditional knowledge. The use of Peer Helpers not only provided volunteers but also linked generations, giving elders and youth the opportunities to spend time together.

Health care and social services were integrated and geared to the needs of regional residents. Providing care at home improves the quality of life for dying people. Often it adds good days to lives that would have been shorter in a hospital or nursing home.

TO FIND OUT MORE

For more information on caring for elders in the village and end-of-life care, see:

Promoting Excellence in End of Life Care

www.promotingexcellence.org/

American Association of Retired Persons (AARP)

End of Life Issues

www.aarp.org/endoflife/

Last Acts: A National Coalition to Improve Care and Caring

Near the End of Life

www.lastacts.org

Principles for care of patients at the end of life

Millbank Memorial Fund. December 1999

www.millbank.org/endoflife/

The May 2002 edition of the Indian Health Services Primary Health Care Provider is the Annual Elders Issue. It includes an article on Marrulut Eniit (Grandmother's House), a ten unit assisted living home in Dillingham. The issue also includes articles on arthritis and osteoporosis in American Indians and Alaska Natives, suggestions for discussing end-of-life planning and palliative care, and "Nine questions to ask yourself about elder care in your community". The Provider can be accessed online at www.ihs.gov/PublicInfo/Publications/HealthProvider/provider.asp.

The IHS Elder Care Initiative (www.ihs.gov/MedicalPrograms/Eldercare) sponsors a listserve to share information, resources, and ideas.

Helping Hands Contact Person:

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REFERENCE CHAPTERS IN HEALTHY ALASKAN 2010, VOLUME I

Chapter 6. Education and Community-Based Programs

Chapter 15. Access to Quality Health Care

Chapter 20. Arthritis and Osteoporosis

Chapter 21. Heart Disease and Stroke

Chapter 22. Cancer

Chapter 23. Diabetes

Chapter 24. Respiratory Diseases

Chapter 25. Disability and Secondary Conditions

Chapter 26. Public Health Infrastructure

NOTES

DIFFICULT DECISIONS

BARROW LOCAL OPTION STORIES

[In the 1870s] the Eskimos had bought a large quantity of liquor from a trader and while under the influence had neglected to hunt for the winter. Following this tragedy the people themselves asked the traders and whalers not to bring any more alcohol to the village.

-Robert Fortune, Chills and Fevers, pp. 296-7

At the end of the last millennium, after many millennia of not knowing alcohol, the small Inupiat community of Utqiagvik was transformed into Barrow, Alaska. During the closing decades of the 20th century, Barrow became a small but modern multiethnic city, the northernmost city in North America. Since the Alaskan Inupiaq people's first contacts with explorers and traders in the early 19th century, alcohol has played a role in the transformation of traditional life. It has been a trade good, a recreational choice, and a destroyer of communities, families and individuals.

People in Barrow, Native and non-Native, have struggled to manage the use of alcohol. Since Statehood in 1959, one tool in that struggle has been Alaska's Local Option Law. This is a story about recent efforts, told in the words of some of the people involved.

Between 1867 and 1959 a variety of laws banned alcohol consumption in Alaska Native villages. Enforcement was minimal. Local leaders and missionaries railed against it, but alcohol always found a way to enter even the most remote communities.

A sporadic, sometimes devastating, problem for Barrow, alcohol abuse became a major public health menace as money began to flow into the community from oil wealth in the early 1970s. Life changed rapidly. The North Slope Borough was formed in 1972. The Native peoples of Alaska and the federal government agreed to settle century-old land claims. TV arrived. Barrow put in place or improved modern community infrastructure: water, sewer, electricity, schools, college and the Internet. Increasing wealth and daily jet services made travel to anywhere in the U.S. or the world a ready option.

In 1959, the State of Alaska passed a local option law to help small communities exercise control over alcohol by banning sales locally. This status is now called DAMP and permits alcohol to be brought (e. g. by mail order) into the community for personal use. There are no State licensed facilities for sale or consumption. In 1980 communities gained the legal authority to ban consumption, sale and importation completely. This status is called DRY. WET status refers to the ability to buy, consume or import alcoholic beverages at or through any State licensed establishment within the community.

In the 1980s and 1990s Barrow saw an intense effort to confront alcohol related issues in various community forums, including the City Council, the traditional Elders' Council and the local option election process. Points of view were often expressed with intense emotions and often provoked equally intense emotions in those holding other points of view. Opinions could differ greatly even among those who held the same position on how to vote. Positions could also vary even within a household. Many "wounds" of the two-decade struggle with difficult decisions were still raw five years after the last election when the following stories were collected. The following are three perspectives on the difficult decisions that individuals and communities face in controlling the problems associated with alcohol.

A Barrow Timeline

1867–1959

Various laws ban alcohol use by Alaska Natives. Enforcement minimal.

1950 Population:

98% Inupiat

1960s

Regular air service, the "Booze Bomber", leads to regular delivery of alcoholic beverages.

1973

City of Barrow opens a liquor store.

1975

Barrow's per capita consumption is 4.5 times the national average.

1976

The liquor store was closed and never reopened.

1976

Barrow goes DAMP. Substance abuse treatment and detoxification facilities open.

MARIE'S STORY

"Barrow is my home and I grew up here. Most of us kids did not know many non-Natives. In the '50s and '60s alcohol was more associated with NARL, the Naval Arctic Research Lab, and the DEW line, the Distant Early Warning site that had its own bar. Local people who had jobs there attended Christmas parties. That was my first view of alcohol. It seemed kind of orderly. But NARL and Barrow were essentially segregated up to the '70s and people were discouraged from mixing socially.

"I went off to high school in the '60s and graduated in 1972, about the same time the borough was being formed and the big infusion of money came. Then I went to college and there were huge changes every time I came back. Barrow would look different and was changing tremendously.

"New people started coming. New facilities were being built; people working here and there, brand new jobs that we'd never heard of before. People had money and were starting to do financially very well. But the new jobs started putting restraints on our lifestyle. You just couldn't easily run off to camp, fish, or hunt and do what you did before. That was the way I was raised.

"The alcohol problem was growing until the '80s when it became really obvious. In the '60s, it wasn't really that common. When someone got drunk everybody knew. In the '70s, we went through a very fast change. I saw some disruptive behavior but not to the extent that I would later see in the '80s where it started dominating people's lives. By the '80s, it was common ... not just alcohol but drugs were also in Barrow.

"In college, I rarely went to parties, but when I came home, it was very different. People were partying all the time, and I joined the scene. It was like what you saw on TV, a different style, the western style of socializing. People appeared to be having a great time but things started unraveling; their families were being affected.

"I realized after about three terrible years that that wasn't the lifestyle I wanted for myself. By '84, I knew that drinking booze was not what it appeared to be when I first came back. It carried a lot of baggage. It was not what I wanted to do. I did not want alcohol to control my life.

"So I started a radio show in '86. We really did not have local news, but I thought it was important to get our own voices heard publicly. I went to the radio station about doing a talk show. I watched all the talk shows I could on TV, listened to the radio, and came to a bilingual format.

"The first series of radio shows was on alcohol abuse. At first it was difficult to get people to talk, but soon it was hair-raising. People started talking about the hurt that they had carried for many years, about sexual abuse as minors where they were in families that were drinking heavily, about people who had lost their dignity and were starting to regain it by not

drinking. A lot of them were still up and down trying to manage the changes that had happened to them. Gradually, it started to become less cool to be out partying and drinking and hurting your families.

“People were starting to see the ravages of alcohol.

“We were in a full discussion of alcohol, not just the availability, but also the problems related to alcohol and it continued into the ‘90s. It became something that you talked about. Most of us had strong opinions on the issues ... some pro, some against. It was talked about for several years to the point where you finally got so tired of it you were ready to settle on wet, dry or damp.

“Through the election process we talked it to death. The positive thing is that it educated a lot of us about the effects of alcohol. Like my radio show in the ‘80s, it was one of the quickest ways to get people aware of the problems with alcohol binge drinking and whatever. The discussion happened, and we hashed it out. People learned that the lifestyle of the ‘80s was not acceptable, not good for your family. It brought about a change in values.

“The local option battles have drawn political lines more than anything. People still have strong feelings. But as a community we came to a compromise.

“I recall my father had to deal with alcohol and he came to a decision really quickly. He would be in his 80s now. He was exposed to what went on with NARL and the DEW line and alcohol was available to him. But he still had his parents who were trained in traditional values and they were not afraid to say, ‘Straighten out. You got a family.’

“But our grandparents’ generation did not have to deal with alcohol at the level that our age group had to. We were the group going through this huge change in our community, not just alcohol and drugs but how to manage your life working on a regular job—you can’t just take off and go camping. It’s a huge adjustment, and no wonder so many people have had big problems. Some started staying up all night drinking in the ‘80s and they’re still doing it, even though they have gone through multiple stays in rehab.

“I also see quite a few young couples who are choosing not to get into an alcohol lifestyle. There are some families that have quite a lot of trouble with alcohol, but there are also a good number of families—young families—who are living a pretty decent lifestyle. They’ve seen the trouble. Some are children of people who partied in the ‘80s and now they are on their own raising their families without it. That’s the positive thing I see: we went through a huge learning curve.”

A Barrow Timeline (continued)

1980
Alaska establishes importation limits for single shipments to Damp villages:

- 12 liters of distilled spirits
- 24 liters of wine,
- 12 gallons of malt beverage.

1990 Population:
78% Inupiat

October 1994, DRY:
Barrow votes to go DRY

October 1995, WET:
Barrow votes to go repeal ban. The election is challenged.

February 1996, DRY:
Barrow votes to restore ban on sales, importation, and possession.

October 1997, DAMP:
Barrow votes to go damp 911 to 789

2000 Population:
60% Inupiat
16% Asian/Pacific Islanders
24% White

May 2000
Community Distribution Center Opens

"My people care for people, more than things. Outsiders care more for things, more than people."
-A Barrow Elder

A Caring Argument Against Dry

"When it was dry, I was afraid for some of my relatives. They would leave town and go on the streets of Anchorage or Fairbanks. To me that was more dangerous. One member of the family was attacked with a baseball bat. I was afraid, too, that the young people would be exposed to AIDS. At least when they were around we could look after them."
-An Adult Inupiaq

ELDERS' VIEWS

The following are comments and observations by Inupiaq women Elders during an afternoon discussion on alcohol, local option, enforcement and the family. Each paragraph represents a change in speaker.

Local Option

"When we first voted alcohol dry in 1980, my nephews, even the one who drinks, didn't complain. I was really glad and I wasn't complaining either. We had a more beautiful life when alcohol was not here."

"The people who didn't grow up here are the ones that really can't take the dry. But the ones who grew up here, even the hardest hard-core drinker didn't complain. But the people from outside, from the other side of our earth, they were complaining."

"Nowadays, many Natives will not speak up for or against wet, but they let outsiders speak for them. When they were voting for wet and dry, there were ads everywhere, you know: 'This is America! We have the freedom to do whatever we want!' There were ads like that. Some people say that people from the outside hear about the election and come to Barrow and live here until the voting is over and then leave. That could explain why it was voted wet."

"They made themselves very, very obvious: cunning and obvious. I remember when I went to vote I saw them standing around the polls the whole Election Day, especially those from out of town, they were standing where people could see them. Just their presence influenced a lot of people."

"I am grateful for the local option laws and it was very good when Barrow went dry. That was the best year. Children were a lot happier. Husbands and wives were doing more things together. The home life was much better. Of course there were people looking for booze and hiding so they could drink it all themselves, but I am very grateful for even damp right now. I'm a lot happier with it damp than wet."

"I prefer dry because when people want to drink they can go out to Fairbanks and Anchorage. It seems better to me because Barrow returns to being a safe place for families and family life."

"I am very grateful when spring comes. That way you know nobody's out there freezing because there is that every year."

"I think it is OK the way it is. If it became dry, it would be very difficult because Barrow has become so diverse. Anyway, it has been voted on before and dry has been overturned. Because of the diversity, dry would not pass."

"But it is very helpful when these elections are being held with hopes of it being dry. We want to continue to keep voting hopefully to end up with dry. But we don't want to stop. We don't want to stop voting. We want to keep fighting as long as we can."

Enforcement

The North Slope Borough Police Department has played a major role in support of Barrow being a dry community since the police saw first hand the effects of alcohol on crime, accidents, injuries, deaths and disputes. Despite sharing a common position on local option issues, Elders are often critical of the police because their values and motivations differ. The police are concerned with law enforcement and justice and usually carry a different set of cultural assumptions. The elders place a higher value on building a caring community and more often see solutions to deviant behavior in terms of restoring health to the community. This distinction is reflected in the tendency to contrast the former Mothers' Club with today's law enforcement.

"I do not want my name made known. I do not think the police do a very good job. Maybe if there were a change, it would work. If the police patrolled more in Barrow the way they do in Fairbanks, they would find someone who was passed out. Right now, it is usually the taxi drivers who find people."

"Before the 1970s, the alcohol problem wasn't very great. But during the '70s, alcohol started hitting the community. There would be folks coming to my house or to other houses where they knew they were safe. Sometimes the floor space would be all filled, any time of the year, at all hours of the night with babies, starting in the 1970s. Even up to this day, we are doing this."

"It is not only alcohol but also drugs. It really hurts me and I am getting tired. Something should be done."

"They make a lot of money on dope here. From outside they come looking and looking and looking for money in Barrow. Bootleggers even use children to sell drugs and alcohol. And the police know about it."

"The police always want strong evidence even though they are being told. But these bootleggers and people selling drugs are still out there. Taxis are very well known for illegal activities. The past year only two have been arrested."

"Sometimes a policeman will pick up a person and they will ship them out to Fairbanks without letting anybody know. Sometimes the husband or wife won't hear about it until after they're out of town and it hurts them both."

"They put Alaska Natives in jail, when they should have treatment. They get out and in a few years, they die. My brother died from cancer five years ago. He had it in jail and they neglected it. It was a neglect thing. He was an alcoholic."

"A lot of times a young person may have suicidal tendencies, they could cut themselves and bleed all over the floor. That's happening too. I'm worried about it."

The Mothers' Club

The Mothers' Club was the early police in Barrow. They started in the 1930s with my older sisters and with a lady that was named Mrs. Grey, a missionary doctor. She was very concerned about children and decided to call all the mothers together and that's how the Mothers' Club got started.

The Mothers' Club was very strong for many years. They raised funds with talent shows and they would sew and make things for sale to get funds. If someone's house burned down, they would make sure that they got money together and sent it to them. Any time there was need, the Mothers' Club was there.

There were shortages of fuel and food and there weren't as many people. But we worked together and everything worked out and we were happy. That was a time when there was no alcohol.

"My dad had a friend who drank quite a bit and I would call the police when they were fighting. Sometimes they would resolve the fighting even before the police came. I wish that the police would be more responsive."

"It is very discouraging that the Mothers' Club doesn't exist anymore. After the police came, the role of the Mothers' Club got just a little bit smaller. There are other organizations now, but we sure miss Mothers' Club again."

Family

"My husband and I never drank. We would never allow alcohol, so there was really no problem until our grandchildren. That's when the problems of alcohol started. Their father drank—their mother started for a while but stopped when they were born. Their father had the problem and because of his drinking, because of alcohol [CRYING], the hurt was because of the alcohol ... The hardest part was watching the divorce of my daughter and my son-in-law. I am grateful for the police because they were there to help. Now that the grandchildren are in their 20s, it has sort of subsided. It has been very hard for me."

"There is a lot of separation because of the alcohol. There are more and more bootleggers. When things were getting a little better with the older son, then the younger son started. My grandchildren start calling on Fridays at about 11 wanting to go to my house. Recently my older son came in and I noticed him reading the Bible and that made me very happy. The younger brother is struggling, not only with alcohol but also with drugs. But he is going to treatment. Is there a way to solve this? The children are suffering the most."

"Once my husband, who was a carpenter, invited his friends over. They were going to have some drinks, and I did not know what drinks were. I tried it and it tasted real good. I told my husband give me another one. He said, 'No! You'll get crazy.' It was probably some sort of wine. It felt hot, but I didn't know what it was. We've heard if you try more, you want more."

"I do not use alcohol myself. I decided at an early age I was not going to use it even at the urging of my husband and his friends. I decided that my children are more important than spending on alcohol or cigarettes."

"This is what I want to understand. I want to know why my children are doing this. I have never used alcohol myself. I think it is because, as children, what really hurt us was to hear teachers and preachers say we should not be talking in Inupiaq anymore. They strictly enforced this rule with punishment and ridicule."

"I've heard people, especially in the villages, say how awful Barrow is because alcohol is so freely available. But what really hurts me is to hear them say we should not be talking in Inupiaq anymore. What I really don't want to see is Barrow being more diverse and with fewer Inupiaq people. This is my home. We grew up here."

"I was born and raised here. Barrow is very subsistence minded and we share. In Barrow when you need fish, they're out there. When you need ducks, they're out there. It's wonderful that we still keep doing what we have done for thousands of years. What I would really like to see is that we pass more of this way of life on to the children."

JIM VORDERSTRASSE'S STORY

How Barrow Went Damp

(After Going Damp, then Wet, then Dry)

Barrow changed its local option status four times between October 1994 and October 1997. Mayor Jim Vorderstrasse explains how the intense feelings of a decade long community-wide debate resulted in compromises through the local option election process.

“When I ran for mayor I didn’t think I was going to get elected. I just wanted to make some positive points. I didn’t run on the alcohol issue, but went public in support of Dry.

“On election night, I had some people over. Everybody left early and I was here all by myself. This guy from Pepe’s showed up with a tray of food from my wife, and said, ‘Don’t feel bad. Don and Nate have been in politics a long time.’ When the numbers came in, I got 800 votes while Don and Nate got 400 each—Nate had been the mayor for 12 years!

“The night that I was to be sworn in, the City Council wouldn’t certify the election because the vote to go Wet passed. It was ugly. I said, ‘This is ridiculous! There is no question that the election took place. We should certify it.’ But they adjourned the meeting so they wouldn’t have to.

“The next day they swore me in but wouldn’t certify the Wet vote. The place was packed and Elder after Elder pleaded with us not to certify the election. The attorney advised that if there was a reason not to certify the election, state it but it can’t be ‘just because you feel it didn’t go the way you wanted.’ The election was certified.

“So I had to deal with the Wet status and it was tough, really tough. I went to the Elders because I wanted their support. I wanted them to give me a chance. I felt I could make some changes and could do some positive things. So I met with them and it was ugly.

“My sister-in-law went with me to translate. First, one Elder stood up—very agitated—and stomped out. Another Elder stood up, my former landlord, and spoke and spoke in Inupiat. I asked my sister-in-law, ‘What did he say?’ He says, ‘You should resign.’

“I said, ‘Resign? Look! Please give me a chance! I didn’t do anything wrong! Why should I resign? I publicly supported Dry in the election!’ There was a misconception that I supported Wet. The people who supported Wet—the ‘Freedom Committee’—felt I would be fair, so they supported me.

“Then, I got sued by my own in-laws. It wasn’t fair. I said, ‘If your son, Etok, was mayor you would have never do this.’ My sister-in-law—whose daughter we had adopted—complained the city hadn’t translated the ballot into Inupiat. It was just a loophole to contest the election. But they went ahead with it. I felt betrayed.

CBS’s 48 Hours

“So then we went wet ... right away we have 48 Hours television crew come up. It was my first experience with the press. They follow me all day around in my office, asking, ‘What do you think people are going to say, what do you think people are going to do?’ I told them forcefully, ‘Well, there will be people hurt from this. There is no question in my mind that people are going to suffer!’ They kept on asking me over and over and I finally said that there are also some people who say, ‘GIMME A BUD!’ This is mainstream America!’

So when they air the program on TV, they cut to me yelling, ‘Give me a Bud! This is mainstream America!’ And I say ‘Geez!’ My mother is calling from Oregon and saying ‘the church women are saying they saw you on TV yelling ‘BUD!’ They showed people at the liquor distribution center carrying out cases of liquor: ‘Free! We’re free at last!’ I was very careful after that.”

-Jim Vorderstrasse

WET: Alcohol may be bought, sold and consumed in any licensed establishment within the community.

DAMP: Alcohol may be brought into the community (e.g. mail order) for personal use but may not be sold within the community.

DRY: No alcoholic beverages may be consumed, sold, or imported into the community.

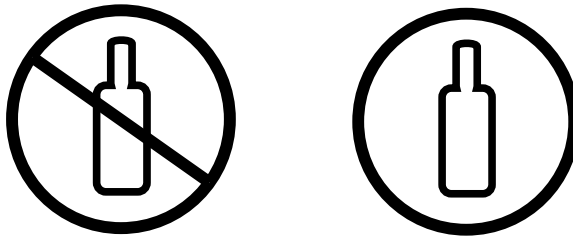
Community Alcohol Delivery Site

A local government may pass an ordinance to control the amount of alcohol that comes into the community legally. The ordinance:

- *sets legal limits on the amount of alcohol an individual may receive in the community in one month.*
- *sets up a Community Alcohol Delivery Site to receive, distribute and monitor the amount of liquor entering the community.*
- *may deny access to alcohol to those who commit certain crimes or misdemeanors, such as DWI, child abuse/domestic violence, bootlegging, etc.*
- *may regulate the delivery site hours to encourage more responsible drinking habits such as weekend rather than drinking during the workweek.*

“Tom Nichols, the head of the Freedom Committee is a very thoughtful person and was willing to compromise. I began to feel I was having some fun and doing positive things. We decided to hold a special election.

“Elections are confusing sometimes. One time you vote ‘yes’ to ban alcohol. The next time a ‘yes’ vote can mean you are in fact voting to lift the ban. The language is such that even after talking about it all the time, the ballot language is still confusing. So, I came up with a bottle and a bottle and line through it. How simple can it be! The Elders also said that some people at the polls were mistranslating the ballot to get people to vote the way they wanted. So we had a certified taped translation done by the Inupiat Language and Culture Commission. I thought these were neat innovations.



“It was really quite stimulating, a true democratic process. We had the vote in February 1996. The outcome was to go Dry by a very slim margin of seven or eight votes. People were scared because restaurants had been lining up to get liquor permits and open bars. We didn’t want any bars here in our town. I didn’t! Not under my mayorship!

“So we went through a two-month Dry period and surprisingly there wasn’t a huge outcry at least not from the drinkers. I guess they were still getting their booze in somehow. There wasn’t much said about it and finally they got tired. We voted again in the fall of 1997 and we went Damp.

“We continued Damp with no changes for a couple of years. Then Tom Nichols of the Freedom Committee talked with me about the idea of a community liquor store and a distribution center in part to keep the money spent on alcohol within the community. I thought these ideas had merit but I told him that he wasn’t the person to bring it up.

“Then Tom was defeated for the City Council and Jimmy Nukapigak was elected. He was for Dry. He brought up with the idea of the distribution center, only this time it was coming from the Dry camp. Under a community distribution center, you don’t change your Damp status, but the City Council can control the amount of liquor you can bring in—without the vote of the people.

“Jimmy proposed it to me saying, ‘we should permit only one bottle a month ...’ or something ridiculous like that. My job was to find a compromise so that everybody could agree. We set the state legal limits—a lot of booze—as a starting point to see how it went. Eventually, we reduced

the limits to about half the State limits. It was still a lot of booze. But it did cut down on a single individual ordering the State limit from more than one distributor. This made bootlegging a little more difficult.

Alcohol is still hurting a lot of people. There is a tremendous Fetal Alcohol Syndrome problem. It is horrible. I toyed with the idea of denying alcohol to pregnant women. But they may not admit to being pregnant, not go to prenatal care, things like that.

And then there are bootleggers—to my mind they're just as bad as drug dealers. They create such pain and suffering and have no conscience. They sell to kids and to alcoholics they know don't need another drink. Yet for money they'll give them a bottle.

As they say, it's the 10% of the people who cause 90% of the problem, but the vast majority seems to be satisfied with how things are working in Barrow now ... at least for the time being."

-Jim Vorderstrasse

WHAT NUMBERS CAN TELL US

Published studies concluded that injury deaths among Alaska Natives in small rural villages decreased when more restrictive alcohol laws were enacted, and that alcohol-related outpatient visits in Barrow decreased when the village was dry:

Berman M, Hull T, May P. "Alcohol Control and Injury Death in Alaska Native Communities: Wet, Damp and Dry under Alaska's Local Option Laws." Journal of Studies on Alcohol, March 2000.

Landon MG, Beller M, Funk E, Propst M, Middaugh J, Moolenaar RL. "Alcohol-related Injury Death and Alcohol Availability in Remote Alaska." Journal of the American Medical Association, December 3, 1997.

Chui AY, Perez PE, Parker RN. "Impact of Banning Alcohol on Outpatient Visits in Barrow, Alaska." Journal of the American Medical Association, December 3, 1997.

Studies on deaths, hospitalizations, and visits to health providers may help in evaluating the effects of local option laws. It is more difficult, however, to evaluate the impact on people who travel or move outside the community and drink in other places. The comments from Barrow residents in the stories above show how complex the picture really is. Health administrators in Barrow are working to document the full picture rather than measuring just the local statistics.

Whether the younger generation in Barrow will have similar attitudes and alcohol use patterns to the older adults will be of interest. If the Youth Risk Behavior survey is used each year in Barrow, the local school system will have information on trends in local attitudes of adolescents.

"I prefer dry because when people want to drink they can go out to Fairbanks and Anchorage. It seems better to me because Barrow returns to being a safe place for families and family life."

-A Barrow Comment

While there may have been a difference in the town of Barrow when it went dry in the 1990s, what we didn't see was a statistical difference in the population. What we saw were Barrow people going to Fairbanks or Anchorage to get what they wanted. So, did it have a true impact for Barrow? Not for the people, maybe for the location.

*-Rebecca Ruhl,
Corporate Compliance
Officer,
Employee-Patient
Care Services
Administrator,
Arctic Slope Native
Association*

"It's tough to give advice to another community. You can't just come in from the outside for things to happen. Don't tell a village what they should do."

-A Barrow Comment

Things to Consider

Barrow is different from many other rural Alaskan communities in ways that may affect which local option choice might work best. Some factors include Barrow's role as a regional center, its multi-generational history as a mixed Inupiaq—non-Inupiaq community; its relatively affluent, highly mobile population, and its modern infrastructure, to name just a few.

Communities considering adopting or changing a local option ordinance, might want to think about and discuss some of the following questions:

- In what ways will the change in local option law affect the actual availability of alcohol? Will it increase or decrease bootlegging? If so, who will be hurt and who will gain?
- Will a change in local option law affect other forms of substance abuse?
- How would a change in the law affect the members of your community who are addicted to alcohol? Do you have a plan to help and support these people? Is there treatment available?
- Is your community willing to have its drinking members go to other communities, such as Anchorage and Fairbanks, to drink and face the dangers and difficulties involved?
- Will your community use the local option election process as an opportunity to educate everyone in the community about all the issues surrounding alcohol? How willing are you to listen to arguments of the other side? What do those who disagree think?
- What do the children think? Will you involve children and youth of non-voting age in the discussion to educate them also? Will you learn about their concerns and visions of the future?
- Will you invite people from other communities similar to yours to come and talk about what has worked and not worked in their communities and why?
- How willing are you to listen and understand the views and concerns of the "other side" and consider possible compromises?
- How committed are you to retaining traditional values and lifestyle? How does alcohol affect these?
- What aspects of non-traditional values and lifestyle does your community see as valuable and desirable for your future as a community and for the future of your children?

TO FIND OUT MORE

The State Alcohol Beverage Control Board (ABC Board)
550 West 7th Avenue Ste 540
Anchorage, Alaska 99501-3556
(907) 269-0350
www.abc.state.ak.us/

Governor's Advisory Board on Alcoholism and Drug Abuse
P.O. Box 110608
Juneau, Alaska 99811-0608
(907) 465-8920
www.hss.state.ak.us/htmlstuf/boards/boards.htm#ada

Arctic Slope Native Association
P.O. Box 1232
Barrow Alaska 99723
(800) 478-3033
www.tribalconnections.org/tcp/map/ak/arcticslope.html

North Slope Borough Police Department
P.O. Box 470 Barrow, Alaska 99723
(907) 852-0311
www.co.north-slope.ak.us/NSB/59.htm

City of Barrow, Office of the Mayor
P.O. Box 629
Barrow, Alaska 99723
(907) 852-5211
barrowmayor@nuvuk.net

North Slope Borough Department of Health and Social Services
P.O. Box 69
Barrow, Alaska 99723
(907) 852-0260

Alaska Federation of Natives
1577 C Street, Suite 300
Anchorage, AK 99501
(907) 274-3611
www.nativefederation.org/frames/health.html

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 4. Substance Abuse
Chapter 6. Educational and Community-Based Programs
Chapter 7. Health Communication
Chapter 8. Injury Prevention
Chapter 9. Violence and Abuse

NOTES

DUMPSTER ART

BETHEL'S HEALTH MESSAGES

"Art washes from the soul the dust of everyday life."

-Picasso

Dumpster art is a creative idea put into practice in Bethel. It accomplishes many things. Two stand out: the artwork encourages appropriate use of dumpsters, and it provides a way to show important health messages in a fun, attractive way. We generally think of dumpsters as useful, necessary and functional, but we also often associate them with an apron of junk that hasn't made it into the box. This story will likely change the way you think of dumpsters, and perhaps how you use them. You will also discover how the painting, the competition, and the messages have changed people, a community, and the state.

Dumpsters are a fact of life today in Bethel. In centuries past, when Bethel was known as Mumtrekhlogamute, there was little, if any, non-biodegradable material to be discarded in the region. Almost everything the people had was used or recycled, and the population was much smaller. Bethel is now one of the largest communities in western Alaska. The larger population contributes to the substantial amount of material that has to be disposed of. The modern materials brought into the community need removal or processing when they become waste.



The creative minds of Bethel have put dumpsters to use and to community purposes way beyond the manufacturers' intent.



We have all heard many times that each person can make a difference and that the smallest effort can have huge impacts. Here is an example of everyday folks accomplishing this. We can take a lesson from the artistic people of Bethel who remind us that resources are all around us, and our best resource is often each other.

THE WORLD IS MY CANVAS

The Idea

"I coordinate the Clean-up/Green-up project for the community under a mini-grant. We decided one of the issues to address was the dumpsters and the areas around them. Part of the problem is that the dumpster openings are up very high and most families have the kids haul the

Kids can make an amazing difference if they're not afraid to voice their opinions appropriately and ask for things.

-Janet Athanas

"My job is funded through the Cooperative Extension Service 4-H program in a shared position with the City of Bethel. So, a group of teens and an adult wanted something different to do in Bethel and formed a 4-H Skateboard Club. One of their initial decisions was that they needed a place to use their skateboards and wanted to develop a park. They went to a City Council meeting. The first time they gave a presentation, they were given property within an existing park to develop a skateboard park."

-Janet Athanas

trash. They can't reach the openings. The Public Works Department also knew it was an issue and we needed to do something about it.

"I grew up in California and remembered that we did something with garbage cans once. If people could paint their garbage cans, why couldn't we do something similar with dumpsters?"

"We worked with the ReCycle Center that had leftover paint people had turned in. They had the paint, and we had the dumpsters. So we coordinated a system with Public Works to use the dumpsters. Anybody could adopt a dumpster. Public Works would go out and pressure-wash them. Folks got paint from the ReCycle Center and went out and painted those things. Then we got three of our biggest vendors in town, our local stores (Alaska Commercial Company, Swansons and ANICA) to donate prizes. The first year, prizes were \$400 for first place, \$300 for second and \$200 for third. We got people who worked in some form of the art field to be our judges, and off it went.

"The first time we did the contest we just had first, second and third prize. We had agencies, school teachers and kids who were painting, so we decided to have an adult and a youth division. That brought it up to six prizes, and the project took off again.

"This year nobody really bought into the dumpster project, maybe because we have been doing it for 5 years. We didn't have a flurry of them painted, but the ones that have been done are all over town. Maybe it's because people don't want to fight over painting over somebody else's dumpster.

"We had people who never thought about painting a dumpster. Then it became an argument about painting over 'my' dumpster. I mean, they went to the city council about this! I couldn't believe this was happening about dumpsters!

"Public Health Nursing, school groups and even individual youth have won. Kids have adopted dumpsters in their neighborhoods. They've painted fireweed and little kids pouring water on the flowers, and a big happy face with teeth. Some of the college students' work was remarkable. This idea also went to the Western Regional 4-H Leaders Forum in Washington some years ago.

"In rural Alaska, dumpsters serve a huge purpose. The Cooperative Extension Service Bethel District is 55,000 sq. miles. You think of it as pristine Alaska. There's little worse than coming to a rural community for the first time and seeing garbage on the ground. The Cleanup/Greenup Project and the Adopt-A-Dumpster Contest have helped make a difference.

"You just don't get it about living in 'Bush Alaska' until you come here!"

-Janet Athanas, Bethel Parks & Recreation Department

Bush Marketing

“The dumpsters are owned by the City of Bethel. Every year there is a competition—there is the Fourth of July parade and the dumpster competition. Everybody gets a dumpster—the actor’s guild, neighborhoods, other programs. It’s an opportunity for everybody to have a billboard.

“Students did the actual painting. They were 6th graders when they did the painting in 1998. We put the dumpster right at the corner in front of the building for Public Health Nursing and the YK Health Education Department, the ‘Y’ in town, the center of town where there is an all way stop so it is really difficult to not see a bright red dumpster with a skeleton head, and that really started a flurry of all these programs—we’ve had diabetes, immunizations, clean water, exercise, and AIDS dumpsters. Ours was the first health one although there was one down by the harbor that had been there for many, many years—about remembering your PFD—personal floatation device. It was the one that set the trend.



“This is a much bigger Public Health Story than the dumpster contest itself. That was the beginning of a year-long campaign that brought the clean air ordinance to the state of Alaska. It was a very large public policy victory! There is a much bigger story than merely the painting of the dumpsters. The dumpsters were one means of communication to support the policy. But there was a much bigger motive behind it than to entertain folks at the stop sign. The main idea was to get the community to gather together and to agree that second hand smoke was a very dangerous toxin that we were allowing persons to spread into the buildings of our community. It was also to get the city council to pass an ordinance to ban smoking in all public and enclosed spaces. It passed unanimously in 1998.

“That education component was driven by a class of sixth graders from Kilbuck Elementary School who did all sorts of interesting things, they created editorial cartoons, wrote letters to the editor, painted the dumpster, did radio advertisements, had a “blow bubbles, not smoke” parade through the center of town, testified before the council on the dangers of second hand smoke, went to Chamber of Commerce and City Council meetings. They even presented awards to members of the community who already had smoke-free businesses, for protecting the kids from exposure to second hand smoke. They were very active in all of these areas which really brought attention to the issue. Even people in the community who smoked themselves realized that children cared about the air that they breathed and made sure that everybody understood the risks they were creating. When everybody understood, they agreed on this ordinance. It is in its fifth year now.

“Since then Anchorage has gone smoke free and Juneau has gone smoke free. Both of those campaigns cited Bethel’s successful passage of the ordinance as examples that it could happen. Only one of those twenty-three kids now smokes—five years later in high school.”

-Caroline Renner, Bethel Tobacco Control Alliance

“It is the most important public policy to change (indoor clean air ordinance) that a community could make to impact public health, and that’s just a fact.”

-Caroline Renner

“Many of these kids had never been to any kind of Chamber of Commerce or City Council meeting. They didn’t understand the effect an individual can have on their community.”

-Caroline Renner

Some Dumpster Themes

Blow Bubbles, Not Smoke

Water, the Drink of Life

Stop the Pop

*Immunize—On Time,
Every Time*

*Imagine Water without
Fish*

*Tobacco—America's #1
Killer*

The 5-a-Day Food Pyramid

*Remember to Wear your
PFDs
(Personal Floatation
Device)*

*Kids are Our Future, Have
You Hugged Your Kids
Lately?*

Pick Up Your Litter

*D.A.R.E. to Keep Your Kids
Off Drugs*

*311—The Non-Emergency
Phone for PD
(Police Department)*

A Volunteer's Memory

"It really affected my family—it helped my dad quit smoking, that's the important thing. We wrote letters to the editor and talked to him. We just started forming little groups and painting dumpsters and trying to get the community into it too. I guess that more time went by and we brought up the subject to end 'freehand' smoking in Bethel and we got an ordinance passed that it was illegal to do that.

"The whole class wasn't involved; just certain ones that wanted to stay after school an extra half hour or something like that and help out."

-Justin Lefner, Student

Here Comes the Judge

"I wasn't surprised at being asked to be one of the judges, I had known about the project almost from the beginning. My son was involved and my sister-in-law started it. It was certainly not the usual art form. The ages of people involved in one way or another was probably eight to the fifties, with most of the actual painting being done by ten to seventeen year olds. The quality was varied and often quite good.

"It blossomed in so many ways. Sometimes there is even a shortage of dumpsters available for adoption. Children were actively involved in not only the painting, but town government, businesses and organizations. Most dumpsters were done by organizations or businesses but quite a few were done by neighborhoods also.

"Somebody even made T-shirts. They went out and took pictures of the projects and had them transferred to T-shirts which were then sold. They sold out fast, you can't get them anymore. They've become collector items."

*-Reyne Athanas,
High School Art Teacher
& Dumpster Art Judge*



WHAT NUMBERS CAN TELL US

In a program like the Bethel dumpster contest, it can be hard to be specific about the numbers of people affected, or to evaluate quantitatively the effect of the campaign. But there are numbers that tell a story. For example, “22 out of 23 youth involved never started smoking” is great progress in any program. Such a record may encourage sponsors, and help keep the program going. It certainly helps participants feel good, so they may go on to more ambitious efforts.

Other numbers can be useful for reporting the level of activity in such a project: the number of dumpsters used, number of organizations and individuals involved each year, and dollars raised from local businesses for prizes each year. The level of activity can be interesting to both participants and outside observers. Measuring the “impact” of such a project may be possible with either quantitative measures (like immunization rates or smoking prevalence changes) or qualitative data, such as the opinions of people in the community about how it has affected their lives.

Qualitative data refers to the information about opinions of participants involved or of other key people in the community. Qualitative results reflect the experience of the individuals. It can be included as valid data in research and in grant proposals, if it is collected and reported objectively and carefully. There are several ways to look at this story from a qualitative point of view. One way is to consider the range and the inclusiveness of the project:

- A Parks and Recreation Department project for cleaning up around the dumpsters moves into art and community beautification, with a public/commercial partnership (stores donating cash prizes) and inter-departmental cooperation.
- It then evolves into a wide-ranging health promotion campaign, energizing intergenerational and intercultural groups.
- The positive public and political action results in adoption of a local bylaw that sets legal precedent. It becomes the basis for similar ordinances in three cities in Alaska.

Or, you can look at how individuals make a difference by creating partnerships of citizens with their governments and with local businesses:

- A Program Director with a very small grant (\$1,500) comes up with an unusual idea for painting dumpsters that the City Council, Public Works Department and the Recycling Center endorse and support.
- Families, neighborhoods, programs and organizations get involved and energized, and volunteers from 8 years old to 50 and up apply for the messy job.
- Youth get behind the program, and the messages, so strongly that they become involved with local businesses, the newspaper and city government.
- At least one entrepreneurial person gets a successful small business enterprise out of it.
- Five years later, youth continue to become involved with city government.
- Anchorage and Juneau pass indoor clean air ordinances partially based on Bethel’s success, then Barrow joins the list.
- Beyond the cities, many villages and towns have either formal or informal rules that accomplish the same purposes. In fact, 123 Alaskan communities have some form of formal or informal indoor clean air policy (from information provided by the Alaska Native Health Board, Support Center for Tobacco Programs).

To tell about a project's effects, you can also consider using percentages. You can report the percentage of stores involved, or the percentage of council people voting positively.

The big story here is simple and awesome. Twenty-three sixth graders from an interior elementary school helped change the course of the future for six hundred thousand Alaskans!

THINGS TO CONSIDER

The joy of brainstorming with a group is that it is energizing to think “outside the box,” which is exactly what must be done to create a new angle on doing things that get your audience's attention. There is a wealth of common-sense information among average people who take advantage of the freedom to create.

If you have an idea for a project, who might you consider approaching to help get it rolling?

- Talk to your city, town or village governing body. These are people, your neighbors, who are actively looking for ways to make the community better.
- Who would benefit from what you are trying to do? Perhaps a petition or a committee might be formed to come up with a plan.
- Have you talked with local business people about your idea? As with the people in government, these people too are neighbors and have a stake in the community.
- Even if the people you talk to can't give you much help, they might know someone else who has experience in what you are trying to do. Don't be afraid to ask for phone numbers of anyone they think might help.
- Search on the Internet for other program ideas. It is quite possible that someone else has had a similar idea, saving you a lot of work.
- Feel free to contact your legislators for help. They might know of resources that nobody else has thought of.



TO FIND OUT MORE

Financing Health Promotion through Sport and Arts Sponsorship
www.who.int/archives/ntday/ntday96/pk96_8.htm

Canadian Social Marketing Resources
www.hc-sc.gc.ca/hppb/socialmarketing/2/resources.html

Social Marketing
www.mkt4change.com

Novartis Foundation for Sustainable Development:
The Social Marketing Concept
www.foundation.novartis.com/leprosy/social_marketing.htm

Creative Problem Solving
www.vta.spcomm.uiuc.edu/PSG/psgl4-ov.html

Project Renaissance
www.winwenger.com/mind.htm

Alaska Native Health Board, Support Center for Tobacco Programs
3700 Woodland Drive, Suite 500
Anchorage, AK 99517
(907) 743-6118

Alaska Health Education Library Project
www.ahelp.org

Alaska DHSS Division of Public Health, Health Promotion Unit
www.hss.state.ak.us/dph/chems/health_promotion/default.htm
(907) 465-3027

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 6. Educational and Community-Based Programs
Chapter 11. Environmental Health
Chapter 16. Maternal, Infant and Child Health
Chapter 18. Immunization and Infectious Diseases

NOTES

DON'T GIVE UP

DILLINGHAM'S PEDESTRIAN/BIKE PATH

"It was the community. We couldn't have done it on our own."

-Lois Sorensen

Pedestrian Bike Path Coalition

Dillingham is one of a few communities off the main Alaska road system with a paved pedestrian/bike path. This is a story of how this community “came alive” overnight to fight for the inclusion of the bike path in a road paving project. It is also the story of how the community “came alive” with activity once the bike path was completed. The path is a safe, year-round place for all members of the community to exercise, play and socialize.

Prior to fall of 1998 a few die-hard Dillingham residents regularly walked, jogged or rode bikes for recreation and exercise. If they did, more often than not, they shared a bumpy, muddy trail with four-wheelers and snow machines. One such trail paralleled two and half miles of the road that connects Dillingham with Aleknagik.

Early in 1998, users of this old trail learned of State plans to pave the Aleknagik Lake Road that summer. They spread the word to others interested in walking and biking and seized the opportunity at Planning Committee hearings to encourage the City to include a paved trail as part of the project. In March, the City of Dillingham requested funds from the Aleknagik Lake Road project be appropriated for a pedestrian/bike path alongside the road. The City earmarked funds up to \$300,000 for the project. The Alaska Department of Transportation (DOT) gave a “thumbs up” to the project upon hearing that the City of Dillingham passed the resolution.

In June, three months after the city passed the resolution, residents watched as road construction began. Walkers and joggers no longer had access to the old trail, but they felt it was only a temporary inconvenience. They were sure that in a few months their new paved path would be ready.

Suddenly, word spread from the city administration that there were no longer plans for the inclusion of the pedestrian path in the project. Residents were shocked. Not only were they not going to get a paved pedestrian bike path, but the old “home-grown” trail was being destroyed.

The community did not give up, even though project completion was just a month or two away. The Mayor, City Manager and some interested residents met with representatives of DOT and the contractors. City officials helped locate copies of policy statements that Governor Tony Knowles and the Commissioner of DOT issued three years earlier. On June 5, 1995 the Governor had established the following policy:

“It is the policy of this Administration that accommodations for both bicyclists and pedestrians shall be included in the design for all projects, including those under construction, where reasonably possible, and shall be constructed where economically feasible. This means pedestrians and bicycle facilities will often be more successful when separated from the road and buffered by vegetation.”

Coalition Comments

"I have a 10 year old son who is riding his bike constantly. First we found out the road was going to have no room to walk or run. Then they said, 'It's too late. Too bad.' We thought that was out of line. Four or five of us got together and we hit town hard and got a massive number of names on the petition in under a week."

-Teresa Duncan

"Our original focus was safety—we were watching kids on their bikes nearly getting wiped out every day and cars not paying attention. And that continues to be true where there is no place that kids can walk and ride safely."

-Cristy Tilden

"I had a pretty full plate with two small children and Grandma in a wheel chair. But the girls called so I mailed postcards and worked on the petitions. In a little place like Dillingham we always pull together and do what we have to do. I don't think anybody could ever starve in our town."

-Patty Luckhurst

"We succeeded because we were all smart enough to know that we couldn't wait on this. If we didn't do it then it wouldn't be done because the equipment would be gone and wouldn't be back for a long time."

-Marilyn Rosene

Two days later the Commissioner of DOT issued the following policy:

"It is the policy of this department that accommodations for bicyclists and pedestrians be considered and implemented for all of our highway projects. Exceptions to this policy will be made on a case-by-case basis."

The Coalition is formed

There was no time to waste. Several citizen activists now adopted the name of the Pedestrian/Bike Path Coalition. With one meeting, the group divided up their work: identify people who could make the path happen; draft letters; develop a petition; gather signatures; mail the letters and petitions; and then follow up with phone calls.

They gathered 850 signatures quickly—even though it was fishing season—demonstrating the broad community support as well as the widespread dismay at the disregard for stated policy and understood agreements. They drafted letters placing emphasis on safety, health and quality of life.

The coalition sent the letters to the Governor, legislators and anyone else who might be in a position to help. The Coalition sent the formal petitions and attached formal statements of support from the Bristol Bay Area Health Corporation (BBAHC), the Dillingham City Council, the Dillingham Planning Commission, the Dillingham Comprehensive Plan, and the policy memoranda of the Governor and the Commissioner of the DOT.

Next, coalition members followed up their letters with phone calls to all the recipients. Finally, the action centered on John Horn, the Regional Director of DOT, in Anchorage. He was a bit overwhelmed by all the phone calls and requested that the Coalition select one spokesperson.

The Negotiations

Janice Shilanski, a dedicated walker and one of the original members of the group that advocated for a paved path, assumed the role of spokesperson for the Coalition with John Horn. Her late husband, Rick, was known in the community as the "Road Warrior" for his relentless pursuit of safety issues in general and the Aleknagik Lake Road paving project in particular.

Janice Shilanski recounts the Coalition's negotiations with the Department of Transportation:

"When John Horn told me DOT didn't have the money, I said, 'John, This is ridiculous. At least tell us how much it would cost. If you are going to say 'no,' at least tell us how much it would have cost. Are we talking half a million? Two hundred fifty thousand? That's peanuts when you are talking about a job worth millions and millions. You're destroying our bike trail. This is ridiculous! You have all this heavy equipment come out and you spend all those millions of dollars and you can't spend the time to put in a bike path? We were told by the project manager that they had the time to do it and they would have no problem putting it in.'"

“At that point I thought it was just bureaucratic baloney and I kept hassling him. ‘John, I am just appealing to you from our hearts. It is just ridiculous to bring this many millions of dollars of equipment out here.’ I repeated things.

“He eventually called back and said, ‘How about we put the paved path in for the first mile and half?’ I said, ‘It sounds like you’re bargaining with me. I can’t speak for the whole group. But I want the whole thing. I don’t want just a mile and a half.’ He said the first mile and half was going to cost around \$250,000. And then to go around this one culvert it was going to take about another \$150,000 because it was ‘an environmental thing,’ cutting across the creek. I said, ‘Well, I can’t speak for the group but I’ll take the first mile and half anyway.’ He didn’t feel that they could finish the whole project that summer if they had to get permissions and everything.

“It was done in a couple of weeks. It was quick! It boggled our minds. They had given us all these hassles. It was just bureaucracy. And I guess that is why I think the story needs to be told. If it truly cost \$250,000, as they said, that is nothing in a project like this for something so good.”

On July 7, 1998, only three weeks after the Coalition formed, Governor Knowles issued a press release announcing the approval of the bike path for Aleknagik Lake Road. He underscored that the path was part of his administration’s continuing effort to provide Alaskans with routes for alternative transportation and access to recreational facilities.

The Project Engineer’s View

John Sorenson served as the Department of Transportation and Public Facilities’ Project Engineer for the Dillingham Project. He shares his view of the pedestrian/bike path’s story.

“When a paving plant and all the equipment come to town it is a big deal. It’s like a circus. Apart from the road project, people can do other jobs privately: parking lots could be done and driveways put in so kids can put up their basketball hoops. Kids are always shooting basketballs. That’s one reason we decided to go with asphalt instead of high float chip seal pavement. Another reason was that a local Dillingham kid did a science fair project that showed everyone that asphalt was a superior product. So everyone wanted asphalt. It makes all these other jobs possible ... including a bike path. When an asphalt plant comes to town it is huge.

“I knew the petition for the bike path was going on out there. But when things reach me there is no real way for citizen input. I have a set of plans, a contract and a budget. I have a little negotiating room, very little. I tell people, ‘I have all the power in the world—as long as my boss agrees.’

"I came from a big family. Whenever the kids wanted something they would put me in front: Go ask Mom. So, I wasn't afraid to pick up the phone and call. I think that is what people are afraid of. What's the worst that can happen? They can say 'no.'"

-Janice Shilanski

"The original plan we heard about in the DOT public meetings was for a complete road with a complete bike path. Each time they came to town the project got reduced. It didn't matter what we said. They claimed—probably rightfully so—that the money got so reduced from the budget that they had to cut somewhere and it was always the bike path."

-Mark Lisac

“I went to a meeting at the city and Coalition members were there demanding things. I told them I couldn’t do a damn thing. The contractor was there and he got heated and said, ‘Why don’t you go call the governor.’ They must have done something like that because my boss called up and said, ‘They want to get a bike path out there. Is there any way you can do it?’

“Bike paths can be complicated. You can’t just build them over anything. There are drainage issues, big fills and cuts, buried utilities and rights of way. You have to figure out elevations. Elevations and grading can be tricky. It is not as simple as people think.

“I didn’t know how we could do it when my boss asked me. We didn’t have right of way. We didn’t have plans. You can’t just add things all the time. We have budgets. I could have said, ‘No, I don’t think we can.’ But I kind of stuck my neck out. For me, it was a growth thing—making the call that it could be done. I didn’t know how, but you trust people.

“There was a really good construction crew. The dozer hands and grader checkers and those types of people knew how to make it happen. You could tell them to go out and do it and they could build it. Most of them were not local guys. But you could see they liked Dillingham. But they were all professionals. Believe it or not, people have a lot of pride in their work. When they leave a job they want to see it right. Nobody likes to see bumps in the highway. So they made it work.

“Everybody wanted to make it work. We started building the bike path before we actually had the right of way. We went on time and materials and everybody was happy. It wasn’t a big fat hog.

“We stopped at a creek. It was the natural place, given the budget and complications. If we went further there were issues that I didn’t want to deal with. There was a pretty steep driveway. If you had the bike path alongside the road, the driveway would have to go down really steep. It was just another complicated problem. There were also more buried utilities. You can only deal with so much uncertainty. And, of course, we ran out of oil for the asphalt. We were right at the end of the construction season. It snowed a few days after we finished the path.

I am still working with the same construction crew. It has been four or five years and we have had a number of construction jobs together since then. But we still talk about that job. Dillingham was such a neat place. You don’t get that every day.”

The Path Becomes a “Park”

The pedestrian/bike path was an immediate success. “The whole town came alive!” as Janice Shilanski put it. Another Dillingham resident, Christine DeCourtney, recalled that even before they completed the path, people “rode bikes and walked on the completed sections until turned back by amiable construction workers who promised, ‘We’ll be finished soon.’”

The path quickly became a place for more and more types of exercise and socializing. The people of Dillingham began calling it “the park” and using it throughout the day and through the four seasons.

The cost of path maintenance was a serious concern from the beginning. “The trail would never be used in the winter.” However, the first snows saw a man whose wife was recovering from cancer hook a plow to his ATV to clear a safe walking path to help rebuild her health. Other volunteers sprang to life to keep the trail a safe place to walk. The people of Dillingham have “owned” the park from the very beginning.

A year after the bike path was completed Christine DeCourtney reported in an article for a monthly magazine, *Ruralite*:

"Now, inline skaters, bikers, walkers, and joggers share the path. Wheelchair athletes no longer depend solely on a few dangerous miles of paved road. Elderly couples stroll along the path, arm-in-arm; people walk dogs; and dads breathe hard as they run along side children wobbling on new bikes. Parents carry babies in backpacks or push strollers sharing afternoon walks with friends.

"The weather doesn't seem to matter—bug nets, colorful baby rain gear or fleece appear as needed.

"The bike path inspires community spirit and ingenuity. One resident, Tom Eveslage, built a rustic bench from logs and placed it along the path. Elders rest on it or giggly schoolgirls perch on it during a break from a game of hopscotch.

"Alaska West Supply, a local building supply company whose property adjoins the path, installed a portable toilet and posted a sign on the door: 'Outhouse provided for your use, free of charge ... Enjoy the bike path.'"

Running groups meet at the path on certain days each week to work out together. The annual Tony's Run, honoring a slain Dillingham policeman, now incorporates the path as a part of the race. Roller blading has been introduced and is popular. People who never walked before now park cars at one end and walk back and forth, then they get into their cars and go home. Organizations have health promotion programs. People clock their walking times. Additional paving of the Aleknagik Lake Road pedestrian bike path is planned for the next time the "paving plant circus comes to town." In the meantime, it is not uncommon to see City Manager John Fulton or Norman Heyano of DOT operating heavy equipment on their weekends to sweep or plow the walkway or other volunteers pitching in as needed.

More benches have appeared over the past several years. In the summer of 2002 a new bench appeared anonymously on the pathway. It has the inscription "Shilanski Park" to honor Janice's Shilanski's late husband, the community's health and safety "Road Warrior."



"I commute to town on my bicycle each day and often return after dark. I do this to maintain a health and fitness regimen. If it wasn't for the safety of the path, I'd be driving a car and losing out on a great aerobic session."

-Jon Sorensen

Diabetes Prevention

"When we developed the Walk to be Fit program we used the bike path to stage a kick off promotion in June of 1999 and again in 2000. I am always encouraging diabetic patients here in Dillingham to go out and walk the bike path to gain control of their diabetes by walking and controlling the weight. In the last year we have been giving them pedometers and they go out and challenge themselves to walk more and more. We have been trying to do more awareness of the importance of exercise and I see more people using it all the time. It is so important to have a safe pleasant place to walk."

*-Lois Schumacher
Kanakanak Hospital*

WOW!
Exercise decreases the risk of heart disease, diabetes and cancer, and also improves lung function, keeps bones strong and makes people happier!

"Unlike a small village where you need to visit with your neighbors just to get from one place to the next, in Dillingham people tend to bustle around isolated in little cars. The path appeals to that need we all have to smile and to nod our heads in the park to somebody else—those little everyday interactions that make life worth living whether we know it or not."
-Cristy Tilden

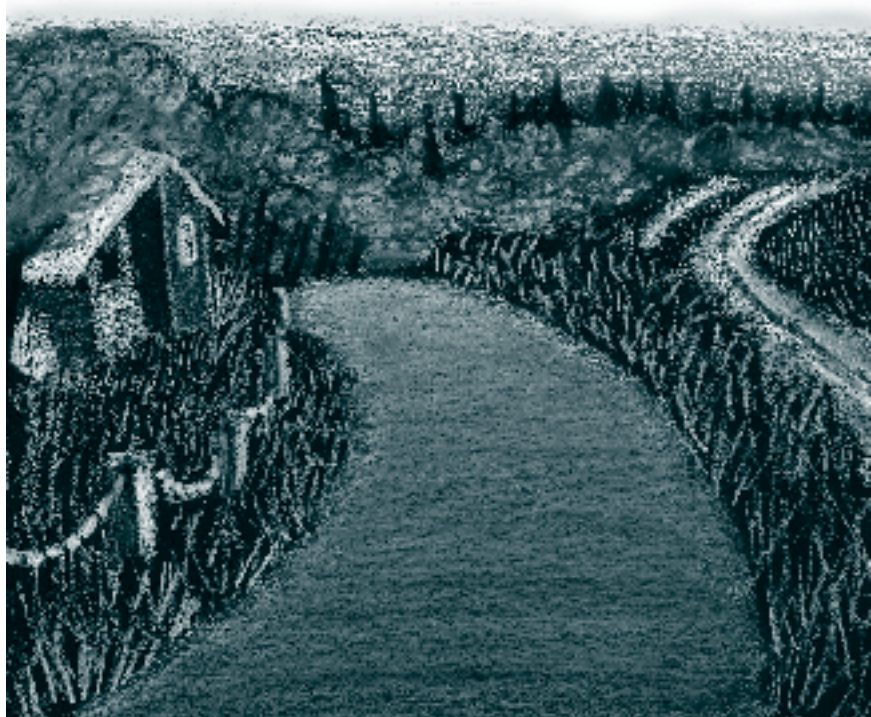
WHAT NUMBERS CAN TELL US

Regular exercise by youth and adults is an indicator of good health. It is considered a “leading health indicator” in state and national plans. This means that statistics about regular exercise habits are considered to be among the most important statistics describing the overall health of the population.

Alaska’s Division of Public Health regularly conducts the Behavioral Risk Factor Surveillance Survey to find statewide and regional patterns of regular physical activity. Only 25% of Alaskan adults currently report engaging in regular, moderate physical activity. The State would like this number to climb to at least 40% by 2010. Communities with safe and enjoyable opportunities for biking, walking, and other forms of exercise should be able to achieve an even higher level than this modest objective.

To find out how kids are doing, there is a periodic survey in high schools and middle schools. The most recent information shows that Alaskan kids (72%) are more likely than American kids in general (65%) to get regular vigorous physical activity or sports. The target for Alaska is 85% by 2010. Communities can help increase physical activities by providing opportunities for residents to get regular exercise.

In Dillingham, residents used petitions and letter writing effectively to demonstrate demand. They were also effective in arguing in their letters and petitions that there were few, if any, safe opportunities for basic forms of exercising like walking, jogging, skating, biking, etc., especially for kids.



Another low cost strategy for measuring demand for a health promotion project is to count the number of users. For a free public access facility like Dillingham's "park," this could be done by periodically counting the number of users on different days of the week or different times of day, by recording the different types of users, or a combination of both. High school students could get experience with "research" by designing a survey and analyzing the results. Their research could be about the use of an existing resource like the Dillingham bike path, or about community interest in a new facility or resource.

THINGS TO CONSIDER

Traditional Alaskan lifestyles have always included vigorous physical activities like hunting, fishing and food gathering, walking and dancing. New lifestyles have brought the challenge of finding opportunities for regular physical activity. In larger urban areas, the opportunities for safe regular exercise are numerous. Health clubs, bike paths, swimming pools, ski areas, parks, bowling alleys, and organized sports for children and adults, to mention just a few, broaden the range of choices.

Dillingham residents used the 1995 policies of the Governor and State Department of Transportation and Public Facilities to have their pathway upgraded into the "park." The 1998 federal Transportation Equity Act for the 21st Century also strongly supports bicycle and walking accommodations in road and highway construction projects. While neither the state nor federal policies require the addition of pathways to roadways, they do require that bicyclists and pedestrians be considered and accommodated.

Communities can get help in developing and promoting ideas from the Bicycle and Pedestrian Coordinator at the Alaska Department of Transportation and Public Facilities. The "Bike Ped" Coordinator keeps up with latest developments in bicycle and pedestrian design and planning and works with transportation planners and engineers to ensure that the needs of bicyclists, pedestrians and other types of users are safely addressed in State transportation

projects. The coordinator is also available to work with communities to give technical feedback and advice. While the coordinator does not get involved in specific projects, he or she can refer you to the person in charge of a project, and help work it through the bureaucracy.

The State's Trails and Recreational Access for Alaska (TRAAK) program offers several funding opportunities, the largest of which is the Department of Transportation and Public Facilities' State Transportation Improvement Program (STIP). The STIP includes a separate category for TRAAK projects such as pathways, waysides and other transportation enhancements that are above and beyond the normal road construction project. Anyone can nominate a project, though projects supported by local communities tend to score higher.

Smaller recreational projects can be funded through the Department of Natural Resources' Recreational Trails Grant program. They are available annually for educational and trail building projects, with applications due in September or October. Data on potential or current users, and evidence of community support, strengthen the application. Letters of support from individual citizens, public figures, agencies and organizations are good ways to show the importance and need for a trail or other health promotion project (www.dnr.state.ak.us/parks/grants/trails.htm).

Does your community need a pedestrian/bike path or some other project or facility that would promote health, bring the community together, and enhance the quality of life? Dillingham's "park" has been successful because the community really wanted it. Only the community itself can say what it really wants. That is what ownership is about.

The Coalition That Didn't Give Up

Mike Davis

Theresa Duncan

Sam Eveslage

John Fulton

Cindy Frye

Phil Frye

Chris Hladick

Wendy Hladick

Denise Lisac

Mark Lisac

Patty Luckhurst

Dee O'Connell

Dan O'Connell

Marilyn Rosene

Janice Shilanski

Jon Sorensen

Lois Sorensen

Cristy Tilden

Julie Woodworth

In Dillingham it was easy to tell what people wanted because they had already created it. But safety was a problem. They needed to pave the old, bumpy, trail to make it safe and versatile. When they did, people came in droves.

Discover the resources and opportunities that are available to promote your project. If your project is a bike trail, you should ask yourself the following types of questions:

- Does the State have plans for paving projects in your community?
- If so, do the plans include a pedestrian/bike path or opportunities for construction of a pedestrian/bike path? If not, find out why not.
- Does your local government have plans for walkway accommodations? If not, find out why not.
- Keep in mind it is possible to use existing State of Alaska right-of-ways.

No matter what your project is, discover and create support for it around town. Don't leave out any groups: parents with infants, children, teenagers, adults, persons with disabilities, the elderly, couch potatoes and the hard core fitness enthusiasts. Find out what is important for each group and what needs a pedestrian/bike path would really meet. Circulate a petition.

- Gather as many signatures as possible, including children's. Kids do count.
- Emphasize the important issues: safety and health.
- Mail a letter to each official and include a copy of the signed petitions.
- Select a person in your group to follow up with a phone call within one week.
- Don't give up! If it is really important, make it happen.

Get your local government to pass a resolution clearly stating the importance of the project to the health, well-being and safety of the community and send a copy of the resolution to any and all officials who may be in a position to help—especially those with some personal ties to the community. Some good contacts to consider include:

- The Governor directly or through the Governor's office in Juneau or through the nearest regional office.
- The Commissioners of Transportation and Public Facilities and Health and Social Services ... or their nearest regional directors. The Governor's Office should be helpful in identifying the most appropriate contacts.
- Local Council or Assembly members
- The state senator for your district
- The state representative for your district

If a state, federal or local government agency is important to your project, you have a right to expect that the officials you talk with help you understand the issues involved. If you don't understand, do not be afraid to ask questions. If you are not getting the cooperation that you think is reasonable, then seek assistance from someone who might be able to help: the head of the office or agency, an elected representative, etc.

Whatever you do ... DON'T GIVE UP!

TO FIND OUT MORE

Physical Activity and Preventing Disease
www.aspe.hhs.gov/health/reports/physicalactivity/

Guide to Community Preventive Services
www.thecommunityguide.org/home_f.html

Federal Highway Administration Guidance
www.fhwa.dot.gov/environment/bikeped/bp-guid.htm

Alaska Department of Natural Resources
www.dnr.state.ak.us/parks/misc/trails.htm

Bicycle and Pedestrian Coordinator
Division of Statewide Planning
Alaska Department of Transportation & Public Facilities
(907) 465-4070

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 1. Physical Activity and Fitness
Chapter 7. Health Communication
Chapter 8. Injury Prevention
Chapter 20. Arthritis and Osteoporosis
Chapter 21. Heart Disease and Stroke
Chapter 23. Diabetes
Chapter 24. Respiratory Disease
Chapter 25. Disability and Secondary Conditions

NOTES

CREATING HEALTHY COMMUNITIES

TURNING POINT

"While there is a clear need for careful and accurate collection of information to keep us informed, there is a parallel need to hone the human skills of relationship building, sensitivity to our cultural differences, community leadership, and a willingness to work together for the betterment of our community."

*-Sitka Turning Point Towards Health Community
Health System Improvement Plan, December 1999*

Turning Point communities in Alaska—Sitka, Kenai and Fairbanks—are among the scores nationwide awarded grants in 1996 by the W.K. Kellogg Foundation as part of a project called Turning Point: Collaborating for a New Century in Public Health. Turning Point's goal is "to transform and strengthen public health infrastructure so that states, tribes, communities, and their public health agencies may respond to the challenge to protect and improve the public's health in the 21st century."

The Alaska Division of Public Health partnered with Alaska's Turning Point communities to apply for funds from the Robert Wood Johnson Foundation. In 1997, the foundation awarded funds to Alaska for developing a public health system improvement plan. Among ten goals identified in the Alaska Public Health Improvement Process (1997–1999), one goal was identified as the priority for implementation: development of public health data that would be useful for communities, as well as for state policy makers. Each of the communities has worked with the Division of Public Health to list the data they most wanted to have as "community health indicators." The Division has been working on regional health profiles, on better lists and links to resource materials, and on development of a user-guided system for finding needed data, to fulfill the expectations of the project. In addition, Turning Point community representatives have been part of the Healthy Alaskans Partnership Council, the group that advises the Division of Public Health in developing *Healthy Alaskans 2010: Targets and Strategies for Improved Health*.

In the pages that follow, Sitka, Kenai and Fairbanks tell about their efforts to improve health in their communities. Each community has a different experience with "collaboration" to improve "public health."

CREATING A HEALTHY COMMUNITY - SITKA TURNING POINT TOWARDS HEALTH

By Partnership Members

How It Began

In September of 1993, the Alaska Pulp Corporation mill, Sitka's largest employer, shut down. The closure raised many concerns relating to our community health. Top on the list was economic recovery. How would Sitka replace the jobs and economic benefits the mill had provided? Significant numbers of displaced workers and their families moved out of town. The decrease in student enrollment in our schools caused decreases in school funding. Local business revenues declined, as did the City and Borough's sales taxes. There was heightened concern about the social impacts related to stress in families affected by the closure. Over the years of the mill's operation, a deep divide

between mill supporters and environmentalists had developed in Sitka. The arguments had pitted citizens against leaders and company officials, neighbors against neighbors. The civic climate was not healthy, and the community was faced with many difficult decisions about its long-term well being.

Shortly after the mill closure, the City of Sitka, with the help of many citizens, revised its Comprehensive Plan. Work on “the Plan” gave Sitkans an opportunity to come together to address some of the difficult decisions facing the community. The new plan included nine main sections, ranging from land use to arts and culture. One section was dedicated to social services and another one was dedicated to health, illustrating the disconnection between these closely related aspects of Sitka’s well being. The health section listed five goal statements: 1) collaboration of services, 2) reducing alcohol, tobacco and other drug abuse, 3) addressing mental health concerns, 4) encouraging healthy lifestyles, and 5) teen pregnancy prevention. But the plan didn’t tell us how to achieve these goals. Despite much time and commitment to a year long process, the Comprehensive Plan turned out not to be a guide. Many people felt discouraged.

This was the backdrop for the development of the Sitka Turning Point Towards Health Partnership. At the time of Sitka’s application for a Turning Point grant, there was interest in furthering the work that had been started in the Comprehensive Plan. The forming partners wanted something that would not sit on a shelf but would be a useful, meaningful guide or health plan for our community.

The Turning Point Grant

In the spring of 1997 we applied for a grant from the W.K. Kellogg Foundation to support planning to improve community health through system change. A group of five health, business and non-profit individuals committed to review the grant and contributed to the grant writing. We saw our work as a community effort—not just as agencies working on a project. And everyone in the community was invited to participate. This early decision to be inclusive and share responsibilities became an unwritten rule of our functioning.

The Turning Point grant was intended to help communities examine the issue of “systems change” in relation to community health or public health. It also provided extensive technical assistance to support communities in the process. Process was considered more important than product. The tension between processing and producing was a struggle for our group.

When notification that the grant had been awarded came in the winter of 1998, the partnership recruited a steering committee and scheduled monthly meetings. Sitka Turning Point Towards Health Partnership was born.

"Early in our organization's beginnings, youth and elders cautioned us that if we wanted to be inclusive, we needed to use language everyone understood. We encourage participation from everyone in our community. We work hard to make Partnership meetings jargon free."

Our Vision

Our first effort was to develop a strong, collective vision, mission and framework for the work we intended to pursue. After a year of discussion, we agreed on our vision statement:

"A weaving is made up of warps and wefts. The warps are the basic structures, the foundation, the resources, and the stability—the principles that are always intact and true. The wefts are the elements that create change and beauty, the people, the dreams and their relationships, building on the basics—a work of art."

We hoped that this image would help us to appreciate how important each part is to the whole, and that through our diversity is unity.

We saw Sitka's many community health resources, but also saw the separation among agencies. Sitka has a population of nearly 9,000. Sitka has a number of health and social services providers, including two private medical clinics, alternative medicine practitioners, a dozen social service and public health agencies, substance abuse prevention and treatment, mental health, family and youth services, domestic violence, home health care, elder care and two hospitals, Sitka Community Hospital and Southeast Regional Health Consortium, which had a history of operating very separately.

During our first year, our group struggled with trying to understand what constitutes "systems change," and what "public health" means. We were not clear how we could promote "health systems change" when we were not sure we were dealing with a system at all, but a disconnected group of well-meaning organizations, each attempting to do a job to the best of its ability. As we worked to define our health system, we realized it was difficult even for those of us familiar with the many agencies that support health in our community. If it was a challenge for us, then it must be a near impossibility for folks not familiar with what's available. It became clear that this problem of fragmentation needed to be the primary focus of the work of the Partnership.

Defining "public health" was not any easier than defining "health systems change." After much discussion, we concluded that for our purposes, "community health" was a better term than "public health." We saw that our community's health meant healing divisions within the community and creating a climate of trust where people could work together to improve the spiritual, economic, recreational, physical, social, emotional, environmental and intellectual health of our community. Helping to make connections between these seemingly disconnected aspects of community health became another focus for the Partnership.

Unforeseen opportunity helped forward our vision of what we might be able to accomplish. One of our partners, the Island Institute, brought a consultant in to teach collaborative leadership. Several Partnership members, as well as other community members, participated in a two-day workshop. The group brought together for training decided to work on solid waste issues in Sitka. We watched the collaborative process in their work, and the training did a great service in building capacity in our community to convene and facilitate meetings and to learn how to best move issues forward politically. Our Partnership learned from watching the solid waste group work together.

Our Goals

It was difficult for us to figure out how to organize ourselves to create a healthy community. We have three goals in our Community Health System Improvement Plan:

- Create and sustain a mechanism to inform the community and be informed by the community on issues relating to Sitka's health and well-being.
- Develop the capacity to collect Sitka-specific community health information and improve our access to community health data from state agencies.
- Expand leadership capacity in Sitka.

The Island Institute (Sitka, Alaska) is a non-profit organization that provides frameworks for people to collaborate and think creatively about how people can best live together in communities and how people can best inhabit the places where they live. The Institute fosters local and regional communication and education. The Island Institute sponsors the summer Sitka Symposium on Human Values and the Written Word and other conferences and workshops and publishes the periodical, Connotations.

www.islandinstitutealaska.org

We set up three work groups: Engaging the Public, System Assessment, and Health Information and Indicators. Engaging the Public was our means of both communicating to the community what we are about and getting information from the public. System Assessment helped us learn about the missions of agencies, organizations, churches, businesses and other groups; how to document the range of services offered in Sitka; and how to document how money flows into our community for health related programs. The Health Information and Indicators Workgroup allowed us to create a profile of community health and to make it available to the public through the Sitka Community Indicators report.

Community Health Indicators

The Island Institute helped us in our effort to develop a set of community health indicators. The Institute came to the Partnership with a community health indicator project already begun. We worked together to expand and complete the project. Our meetings with the community to explain the Community Health Indicators helped people become aware of community health issues in Sitka and to tell the Partners other issues that were important in the community. City officials also learned from the Community Health Indicators Report and assisted us in developing a second report two years later.

For this second Community Health Indicator Report (2001) over 50 citizens worked on the details of indicator selection and determined the areas of interest to be included in the report. The group also assisted in the interpretation of the data and critiqued the draft. We launched publicity for the report and held two public meetings. The City of Sitka donated \$3,000 toward publishing this report and the City now includes the report on the City of Sitka website.

Sitka Turning Point Partnership's accomplishments began with the planning process and adhering to the written plan. This plan, Sitka Turning Point Towards Health Community Health System Improvement Plan, was developed as a guide for all the work we do. We use the plan to make sure that the actions we take are within the mission of our collaborative. With so much focus on process, it is easy to forget all the "work" that is getting done. Recording and celebrating accomplishments is important work for groups that intend to be sustained.

Community Health Heroes

Sitka Turning Point decided to honor our Community Health Heroes. Our most recent group chosen was the Baranof School Playground Coalition—a collaborative project with the Baranof Elementary School principal and staff, Baranof School Parents Advisory Committee, the City and Borough of Sitka, and the Sitka School District. The elementary school had an extensive remodel but there were no funds to upgrade the playground, which was in very poor repair. Through the efforts of these groups, a wonderful safe playground was created. At the dedication and open house of the school Sitka Turning Point presented a commemorative plaque to be installed in a wall on the playground which honors those who pulled together to provide the children of our community a very special gift, the new playground.

Our plan is important, but equally important has been our openness to opportunity. Learning about agencies and developing trusting relationships have created opportunities for system change. For example, a developmental playgroup for pre-school children lost its meeting space. Now it is housed at the Pioneers' Home, giving the children and their elders a chance to visit with each other. When one of our members became ill, partners realized that Sitka needed a hospice program, and the Sitka Community Hospital helped to set one up. One of our members now chairs the City and Borough of Sitka's Commission on Health Needs and Community Services, providing a link between our work and the City's efforts.

Leadership

Much of the work necessary to affect true community health systems change requires strong and effective community leaders. It also relies on the involvement of people with a variety of perspectives, backgrounds, and connections within the community, including youth. The more we have worked together and come to value the contributions of Sitka's diverse population, the more we began to understand the importance of shared leadership for the Partnership and to see a need to develop new leadership in our group and in our community. We plan to have a Leadership Conference and a series of local workshops in the fall and winter of 2002 on such subjects as:

- The Challenge of Leadership and Creating Change in Communities
- Communication Styles and Differences among Cultures, Genders and Generations
- Principles of Facilitation and Team Building, and Principles of Mediation, Dispute and Conflict Resolution.
- Advanced Principles of Collaborative Approaches to Community Issues.

We see especially that we need to develop leadership among our young people and encourage them to be participants in the life of our community. We will work on this over the coming years.

We are proud of our work in Sitka and proud of the recognition we have been given by the Kellogg Foundation. They have helped us in our commitment to the collaborative process and to consensus decision-making and have given us advice about becoming more diverse by increasing our Leadership Team to include more members and more citizen positions. We have also been encouraged by them to "tell our story." In the January 2002 issue of the Journal of Public Health Management Practices the Sitka Turning Point partnership published an article about our work. The title of the article, "Community Collaboration—A Weaving" was a collaborative effort between the primary authors, Nancy Cavanaugh and Kaats Saa Waa Della Cheney, a local editing team of Partnership members and help from the University of Washington.

We believe in collaboration. In the past, most of the organizations now involved in the Partnership did not think of doing business through collaborative efforts. Encouraging collaborative work within the Partnership and between agencies has been an important part of our work. We see our work as a change agent, facilitating connections between organizations and individuals that go on to improve the health of our community, rather than taking on health issues to solve ourselves.

"Our collaborative relationships demonstrate that people are the most important resource we have."

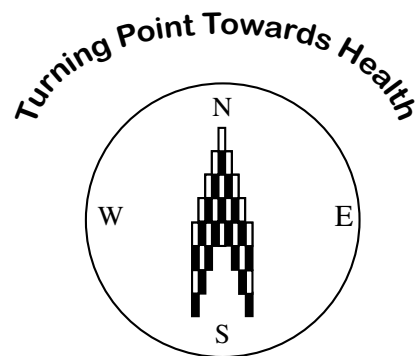
"Turning Point has been an attempt for our small island community to come together to see if we could develop a plan to transform the health system of our community. The goal seemed as daring as a trip to the moon, and we knew it would take time and the commitment of a large sector of the community working together as completely as possible to be successful. We are happy to say we are making progress. There is excitement in the air when we meet. We have much to learn. We have learned much."

-Sitka Turning Point Towards Health Community Health System Improvement Plan, December 1999

Relationship building takes effort. Nurturing relationships means being patient and learning to trust. Decision making by consensus means no one feels we are moving in the wrong direction. We mentor newcomers to the Partnership so they quickly feel a part of the whole. The relationships we have developed through Partnership meetings and events sustain our participation and make it more enjoyable. For many of us, our work with the Partnership has been an opportunity for personal growth and change.

We moved to a "shared leadership model" in our organizational structure. We don't have officers. Instead, we have a Leadership Team of nine members from different sectors of the community whose terms are staggered. This group rotates the role of team facilitator and the full Partnership meeting facilitator. We share responsibility for taking and distributing minutes and meeting notices. To further assure that our Partnership is not associated with any one agency in town, our meeting place rotates among different locations, helping Partnership members learn more about participating organizations and avoiding the dominance that might come of a single organization hosting the meetings regularly.

The logo for Sitka Turning Point Towards Health is geese flying in the familiar "V" formation. Created and designed by Kake Tlingit weaver, Kaats Saa Waa Della Cheney, this logo was woven into a traditional Tlingit basket. Like the geese in flight, our partnership is about working together, trusting the process, sharing the leadership, taking needed breaks and lifting those who need a rest, building relationships, and taking time when all is done to stop and talk about what we have learned.



“Healthy Communities, Healthy People” The Central Kenai Peninsula Turning Point Project

by Healthy Communities/Healthy People

“We are a group of committed members of the community who work together to create opportunities to enhance individual, community, and ecological well-being.”

-Healthy Communities/Healthy People

The Kenai Turning Point project has a history that started before the Turning Point grant. Turning Point’s Healthy Communities/Healthy People (HC/HP) Steering Committee evolved from the Kenai Peninsula Borough Health Care Advisory Council, formed in 1991 to address the borough’s widespread lack of affordable, accessible health insurance.

In 1994, the group collected community input on health issues through a series of Health Forums, during which five major taskforces emerged to address “sustainable economy/environment,” “public transportation strategies,” “strengthening families,” “life skills,” and “kids’ stuff.”

In March 1996, we partnered with the previous Health Fair organizers to host the first annual Village Fair. Since then the Village Fair has become an increasingly well-attended annual event. In addition to 25 standard “health fair” stations, 77 other community groups participate. Master gardeners, pharmacists (checking medications for people), the Watershed Forum, local blood bank, Kenaitze Tribe, and law enforcement officers (taking pictures for the missing children program) are some of the different groups. A charter member of HC/HP has recently taken the Village Fair concept to Russia, through collaboration with the Soldotna Rotary.

In 1997, with funding from the W.K. Kellogg Foundation, Kenai Turning Point developed a public health system improvement plan, “Healthy Communities/Healthy People” (HC/HP). The plan states: “The overall vision of HC/HP is based on a way of looking at health that is inclusive, encompassing and holistic.

The individual, family, community, and ecology which are at the core or hub of the entire Public Health System drive it. This change from the traditional agency, governmental or organizational approach is a significant departure; and, by itself, when fully understood and implemented, will be the most important aspect and improvement in the Public Health System of the Central Kenai Peninsula.”

We have found a better way to do our business. Since July 1998, Bridges Community Resource Center, Inc. acts as fiscal agent for and collaborates closely with the “virtual organization” called HC/HP. Healthy Communities/Healthy People and Bridges have made a difference. Early discussions about transportation laid the groundwork for another group to establish an innovative and successful community-wide rural transit system, named Central Area Rural Transit System (CARTS).

HC/HP’s Mini-Grant Project supported 36 groups and individuals financially for efforts such as a school breakfast program, snow machine helmets for kids, and grant-writer and leadership scholarships. The mini-grant model was so successful that the City of Soldotna and the Soldotna Tobacco Alliance began a similar program.

HC/HP collaborated with Bridges and the State of Alaska to assess and educate the community about oral health needs of low-income children. The Dental Health Assessment showed that we need a broad approach to the community’s complicated and serious oral health problems. A community-wide Dental Health Coordinator was hired and supported by HC/HP until Central Peninsula General Hospital agreed to pay her salary on a temporary basis. Since then, that position has become well established in the community.

Healthy Communities/Healthy People and Bridges worked with the State of Alaska to access federal community health center funds to provide health care to uninsured or underinsured individuals. A new Board of Directors now operates the busy Cottonwood Clinic and will soon establish a local dental clinic.

We have joined with others in the community to deal with local prescription drug abuse. We now have widespread community education activities, advocacy for changes in Medicaid regulations, and proposed legislation for tracking of prescription narcotics.

Our Indicators Committee, with the Borough Economic Development Office and the Health Service Area Board, is completing a community health assessment. Next, we will develop a “report card” on the health and well-being of the community.

Where do we go from here? Some of Healthy Communities’ next efforts will be in partnership with the Economic Development District to identify and decrease community hazards, such as contaminated well water. Another major thrust for the future is to develop a Community Care Foundation. A task force has begun work with “mentors” to create a financially sound, renewable resource for the community, to be used for continued improvement in community health and well-being.

Over the past eleven years of community development, we have learned a number of key concepts. Several themes and characteristics of our community have promoted our process and progress:

- relationships
- leadership
- partnership/collaboration
- diversity/holistic approach
- trust/shared vision
- commitment
- perseverance
- positive energy/focus on “assets”
- have fun!

Fairbanks Community Health Partnership

Fairbanks’s Turning Point project began with thirty volunteers from twenty-six agencies and the community at large donating more than 3,240 hours to develop and begin implementing a health system plan, A Blueprint for Transformation, for Fairbanks.

The Fairbanks Community Health Partnership used some of their Kellogg Foundation grant funds as mini-grants to groups wanting to do a project or service for the Fairbanks community that supported the concept of community health. The Partnership developed a website (www.FairbanksInfo.com) to highlight local health data and a health resources directory. The website encouraged new Partners to share data and decrease duplication in data collection. The Partnership is working with the Youth Asset Building Coalition to improve outcomes for young people in Fairbanks.

Local government officials have been keenly interested in the Partnership’s local data collection and review of local public health related ordinances. The Mayor is concerned about the city’s ability to respond to sudden growth and development and sees the Partnership’s work as essential to that preparation.

WHAT NUMBERS CAN TELL US

Communities can measure what they care about. Health indicators—like the Healthy Alaskans 2010 Indicators, the Sitka Community Indicators, selected indicators on FairbanksInfo.com, and the Healthy Anchorage Indicators—help us measure important issues over time. Good indicators show change over time, are easy to understand, attract media attention, and inspire action. Good indicators can be changed by individual or community action.

You build indicators out of data—the measurements. Health data include information from death certificates and birth certificates, immunization rates, reported cases of certain diseases, and surveys of behaviors (such as smoking or exercising) that affect health. Social and economic factors like education and income are also interesting to track, since they can influence health and are often highly correlated with health status.

Most health data in Alaska is available at the borough or census area level. Social and economic data may be available by school district, labor market region, or community.

Tribal health statistics represent the beneficiary population rather than a specific place. Some communities may create their own data—by counting the number of people using a walking trail, tracking pop sales from school vending machines, or recording the number of serious snow machine injuries in a season.

THINGS TO CONSIDER

What does public health mean for your community?

Alaska's three Turning Point communities are among the scores in the nation funded by the Kellogg Foundation to improve health systems through collaboration. Each of our communities struggled to find definitions for the basic concepts of "public health," "health systems change" and "community health" and to develop a definition of collaboration that worked in each community.

In your community where are the opportunities for collaboration among organizations and individuals?

The Turning Point groups learned that forming partnerships and working collaboratively goes "against the grain" of the way many agencies work. Some of the tools they used to foster collaboration, for example, mini-grants, may have had only short-term benefit. The relationships they built may have longer lasting impacts.

What are the issues in your community that people feel strongly enough about to work on? What keeps them from working on those issues? Would better data help?

Each of the Turning Point projects tried to expand residents' understanding of "public health" and tried to get residents involved in the health planning process. Each has struggled with how to devise strategies that will work, especially when state and local agencies share responsibility for implementation. Data collection about local health conditions was often problematic. But community health indicators did serve an important role in focusing attention on those health conditions communities wanted to change.

Does your community have people to lead an effort to change the community's public health system? How can you develop leaders? Do leaders and community members share a common vision?

Leadership was an issue for all three communities—both leadership for the project and expanding the community's pool of leaders, especially young people. Sitka, especially, focused on developing a new organization that reflected the values in their vision statement—diversity and unity—and adopted a defined collaborative process and collaborative leadership. Their commitment to Sitka and to "hanging in for the long haul" is notable. Similarly, Kenai's Partnership is well rooted in the Central Kenai Peninsula.

Alaska Health Profiles Online

www.hss.state.ak.us/dph/profiles

Start the search for health data here. Population, death rates, births, and health risk factors are all available by borough or census area. Some areas with low populations, such as the Southeast boroughs, are combined to provide bigger base numbers and more meaningful rates. The "important links" for each region and the "resources" list provide links to other sources of health, economic, and social data for Alaska.

What are the conditions that favor continuing effort to improve community health?

The experiences of the three communities call into question what happens when outside funds are used for local projects. Is the community's goal the same as the funder's goal? Will the effort extend beyond the end of funding? What are the conditions that favor continuing commitment to community health? Alaska's three projects show that funds can be helpful, especially to finance staff for such efforts as data collection. But funds can't substitute for local commitment to doing things in new ways. The commitment of local people to the community and its future is crucial in sustaining efforts to improve community health. As in Kenai's Turning Point project, which pre-dated the grant, success may come more from efforts that were not solely dependent on grant funds but were more firmly rooted in the community's history.

TO FIND OUT MORE

Sitka Turning Point Towards Health Partnership
Penny_Lehmann@health.state.ak.us
www.cityofsitka.com

Stan Steadman, Healthy Communities/Healthy People
Kenai Turning Point Partnership
(907) 260-2663

National Turning Point Website
www.turningpointprogram.org

National Association of County and City Health Officials
www.naccho.org

Healthy Anchorage Indicators
Anchorage Department of Health and Human Services
Community Health Promotion Program
www.indicators.ak.org/
(907) 343-4655

The Community Indicators Handbook
Tyler Norris and Alan Atkisson
Redefining Progress, 1997
(510) 444-3041
www.redefiningprogress.org

Coalition for Healthier Cities and Communities
www.healthycommunities.org

The Community Toolbox
Ctb.ukans.edu

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 6. Educational and Community-Based Programs

STRENGTHENING COMMUNITY CARE

TALKEETNA'S SUNSHINE CLINIC

"Alaska residents face some of the most extreme barriers to obtaining health care services in America, the greatest of these barriers being isolation."

*-USDHHS Secretary Tommy G. Thompson
August 4, 2002*

Many Alaskans who live far from urban centers struggle to get their basic health care needs met. Providers are scarce. Transportation is difficult and expensive. Some communities have addressed this need by participating in a federal grant program for Community Health Centers (CHCs). CHCs are private, not-for-profit, consumer-directed health care corporations. Community health centers provide high quality, cost-effective primary and preventive care to medically underserved and uninsured people.

Growth of community health centers in Alaska has been rapid and mostly recent—from one center in Anchorage in 1974 to 19 in 2002. For these centers, federal funding offers financial stability to keep clinic doors open, to expand available services to include dental and mental health, and to increase the number of people served. Becoming a community health center also connects a clinic to statewide and national networks of health care management resources.

Following is the story of how a small community, Talkeetna, started and expanded a community health center.

THE LITTLE CLINIC THAT COULD

By Jessica Stevens, Physician's Assistant-C, Medical Director

As of this writing in 2002, Sunshine Clinic has over thirty employees and manages nine separate programs spanning the gamut from primary care to family advocacy, home health care and, its most recent venture, a mobile clinic. But it wasn't always like that.

Act 1

Our tale begins in 1987 in the Upper Susitna Valley, in South Central Alaska. For the folks who lived in the Upper Susitna Valley there was no local health care for an area the size of Delaware and Maryland. People had to drive between 70 and 80 miles to the nearest hospital, if there weren't too many moose or too much snow or ice on the roads and if they could get out of their remote cabins by dog sled, snow machine or plane to get to that road. A group of committed folk from the communities of Talkeetna and Trapper Creek decided that enough was enough. Spearheaded by a local emergency medical technician, Gail Saxowski, who wrote her thesis on how to start a small rural clinic, the group approached the State of Alaska and got a small Alaska Community Health Facilities grant to start a "mid-level" clinic. They formed an impromptu board, bought a trailer, and hired a part time nurse practitioner.

The clinic went through a series of part time health staff. Underpaid, no employment benefits, working in isolation and with only one clerical support person, each solo midlevel practitioner burned out. The clinic was open sporadically and struggled continuously to make ends meet. Without stable staffing, the clinic could not become a reliable community resource, and clinic revenues stagnated at levels that could not support operations. The idea was a grand one, but the vision was hard to realize.

In 1992 a nurse practitioner left, state funding was suspended, and with \$80 in its bank account, Sunshine Clinic closed. Concerned citizens pooled resources and with \$10,000 raised locally and the state grant resumed, the Sunshine Community Health Center advertised for a physician's assistant in early 1993.

Act 2 (The longest act!)

Act 2 begins in 1993. The thought of a quiet little clinic with only a few patients per day sounded mighty attractive to me. As I sat in a second interview with about 16 community members, I felt the power of commitment and will from the people in the room. As I accepted the position, I had little idea of what the bank account held or the uphill struggle that stretched ahead of us.

The board ran the clinic and oversaw my position. We hired a front office person and opened the clinic full time. Supplies were limited and outdated. My first clinic patient had a huge gash from a chain saw. Donned in a black garbage bag with plastic sacks on my feet, I used expired anesthetic and a miscellaneous assortment of cleaning solutions and sutures to clean and repair his wound. That was only the beginning.

We needed to rebuild the clinic and give people confidence in its ability to meet their varied needs. The clinic began taking calls 24 hours a day. As the only clinician, being on-call sometimes involved three or four round trip visits to the clinic on a weekend day, driving as much as 120 miles per day. People knocked at my door at all hours. I maintained a small inventory of medicines at my home to meet the needs of people who would drop by. We held specialty wellness clinics for women, children and men, using the goodwill and volunteer efforts of many Wasilla, Palmer and Anchorage physicians. We begged everyone we met for equipment, supplies and help. A gentleman driving up the Parks Highway stopped by to ask what we needed. He turned out to be a retired physician from Nebraska who later mailed us an antique electrocardiogram machine and a lung capacity measurement machine. We sought mentors and advisors wherever we could. The

two of us did cleaning, billing, saw patients, developed budgets, fought with insurance companies, and provided veterinary care all in a day's work.

I gave birth to my son at one in the morning in late September 1993, having been at the clinic for a little over five months. The day of his birth, we had an influenza clinic for about 40 local elders, a patient who went into anaphylactic shock, a full day of patients, and an extended board meeting to discuss our financial crisis. The meeting ended at 9:20 in the evening. My son was born at home four hours later. The board meeting planned a spaghetti feed which later raised \$10,000 which allowed the clinic to keep its doors open.

During those first three years, we were designated as a Rural Health Clinic by the federal government, which allowed us to receive Medicaid and Medicare reimbursement. We moved into a tiny family duplex. I saw so many different problems which I felt ill-equipped to deal with. Wasilla health care providers got tired of hearing about our needs, and continuously reminded us that there were no resources available to help those "north of Wasilla." In 1996, after a brainwave in the shower, we applied for and received a Rural Health Outreach grant that gave us funds to provide badly needed additional services, namely, substance abuse treatment, in-home parent support, mental health, and domestic violence counseling.

And so begins Act 3

In 1996, the Sunshine Clinic hired seven additional people and the board began partnerships with several "lower valley" organizations. For the first time, we offered behavioral health services and outpatient drug and alcohol treatment. A second primary care clinician was added, as were a family advocate to work with families experiencing violence in their lives, and a family support worker to offer support to new parents and their babies. We worked hard to consolidate these services which are still in existence today, six years later.

In 1999 Sunshine Clinic received two large federal grants which at last, after 12 years, allowed us to reach the original dream of that first visionary board. We became a federally funded Community Health Center. Finally, we had operating funds to be what we had always been, a community health center. But before, we did not have the funding! We also had funds to work with hospitals and other health care providers in a group called Susitna Rural Health Services. Through this partnership, we were finally able to hire a director, more clinicians, and a care coordinator for a home health care program.

We are always out in the community, teaching at the schools, working with civic groups, hosting a bi-weekly radio program, *Here's to Your Health*, holding health fairs, participating in Talkeetna's famous Moose Dropping Festival, and attending community council meetings. Our participation in these ways keeps us in touch with what people are saying about their health concerns and health care needs.

Act 4: where do we go from here?

Now, in 2002, and reflecting on the past of the "little clinic that could," we have just put our new mobile clinic "on the road." We bought a used Winnebago from the State and will soon be providing services to Trapper Creek and Willow. With funds from the Denali Commission, we will soon have a new, custom designed facility. The new building will increase our capacity for integrating mental health and substance abuse services into our other services. Also, we hope to start a dental program and develop a satellite dental clinic in Willow.

The journey has been a long one, made possible by the help of many incredibly committed individuals. Without them, there never would have been a dream. We struggle to be a model rural clinic, offering an approach to health care that recognizes and integrates physical, emotional, and spiritual health to work towards a healthier community. We think we have made a good few steps in that direction.



"Sunshine Clinic gets an A grade—the phenomenal amount of work people give to make it happen, and staff keep moving the bar higher, striving for excellence. The community has gotten on board, as we've provided a proven level of care. The providers are such good people and so trusted by the community. They are known to be able to do the job and to do it regardless of pay. They've made it clear they will care for people; hopefully people will pay, but care is provided anyway. People know the Sunshine Clinic is there. It's a real blessing to the community."

*David Sutton
Vice-President
Sunshine Clinic
Board of Directors*

"Our communities historically have been marginalized in the eyes of service providers located in more urban environs, and their programs rarely reach our communities."

"Health care problems most frequently diagnosed are diabetes, cardiovascular disease and hypertension."

*Sunshine Clinic, Community
Health Center New Start
Proposal 1999*

About Talkeetna

“Since 1987 Sunshine Community Health Center has brought health care to approximately 5,400 rural residents, without regard to patients’ ability to pay. The Upper Susitna Valley is the northern half of the Matanuska-Susitna Borough, about 12,250 square miles, an area larger than Maryland and Delaware combined. The Clinic’s service area stretches nearly 160 miles along the Parks Highway from Willow to Cantwell, on the edge of Denali National Park, and into Petersville and Skwentna. Population density is about 0.44 people per square mile.

“Public officials often compare people who live in the Upper Susitna Valley to stereotypes of Appalachia—predominately white and poor. The population is among the fastest growing in the country. Adjusting for cost of living, fully 80% of all families in the area live in poverty. Most jobs are seasonal and a large part of the population lives a subsistence lifestyle. Over 40% of the area’s population have no health insurance, a number which has increased since welfare reform. A study conducted by Sunshine Clinic in 1993 indicated that 43% of Upper Susitna households failed to seek health care during the previous five years due to inability to pay.”

Sunshine Clinic, Community Health Center New Start Proposal 1999

A Kodiak Demonstration Project

The Kodiak Island Health Access Project Clinic was opened in October 2001 and closed in March 2002. During those six months of the pilot project, medical care for people without health insurance was available once a month. For years, a group of Kodiak residents had applied for grants and tried other strategies to fund a clinic to provide services to Kodiak’s seasonal cannery workers and their families, as well as to the many fishing families who were also without health insurance. The seafood industry provides one-third of the total employment in the Kodiak Island Borough. Forty-four percent of Kodiak’s population are minorities. Many immigrant minorities are not eligible for federal health programs, such as Medicaid.

The Saturday clinic was supported by a \$60,000 grant from the Kodiak hospital and by in-kind donations of goods and services and volunteer staffing. Interpreters were available for each visit. The Kodiak Health Access Project clinic was open on the first Saturday of each month from 9AM to 4PM. Twenty-five appointments were arranged for each Saturday on first come first served basis. The clinic was promoted in the community through newspaper, radio, and word of mouth. Each Saturday, many more people tried for an appointment and were not able to get one. Many people with greater medical care needs than had been anticipated also tried to receive care. Care was less efficient than anticipated because they could not access previous health care records.

The pilot project showed a great need for drugs for the chronically ill, for example, people with diabetes or hypertension. Other lessons learned were that the clinic needed to be held during the week, and that coordination with other providers was important. Clinic supporters hope for an interpreter with special health interpreter training.

The clinic ceased operations when funding was exhausted. While this volunteer effort was not a long-term solution, some residents got needed medical services, and data were collected that can be used in future grant requests. Importantly, the clinic educated the community about the needs of the medically underserved population in the community and fostered a vision for a future clinic in Kodiak.

Rae Jean Blaschka, one of the staff volunteers, says, “It was a worthwhile experiment.”

Mountain View Health Center

In November of 1999, the dreams of a dedicated group of Anchorage residents were realized when the Mountain View Health Center opened its doors. Today the Mountain View Health Center is operated by the Anchorage Neighborhood Health Center in a collaborative effort with Southcentral Foundation providing medical services to persons living in the neighborhood, including Alaska Natives.

The neighborhood's first clinic opened in 1997 when a grassroots organization, the Concerned Citizens of Mountain View, partnered with the Anchorage Latino Lions Club and Providence Health System in Alaska to improve health care access for the neighborhood. When it was clear that additional space and staff were needed, the clinic moved to new space located in the Mountain View Plaza.

Basic dental services have been started at Mountain View Health Center. Services are provided to adults and children age 1 year and older with or without insurance. Dental services include check-ups, fillings, and preventive care. Walk-ins are also welcome. Services for uninsured patients are provided based on ability to pay.

Interior Neighborhood Health Clinic

The Interior Neighborhood Health Clinic is a community health center that offers basic preventive and primary health care services to families in interior Alaska on a sliding fee scale. The Interior Neighborhood Health Clinic works in cooperation with other health care providers to increase the health and medical care services available to communities. The clinic is managed by a local non-profit group, the Interior Neighborhood Health Corporation.

The clinic seeks to fill the large gap for those who need primary medical care but have financial or other barriers. Services are provided on a sliding fee scale, for those who do not have adequate insurance or do not have Medicaid. During calendar year 2001, the Interior Neighborhood Health Clinic served 4,762 patients. Nearly 50% (2,306) were uninsured; 52% (2,479) live at or below 200% of poverty.

Grant revives closed clinic

WHITTIER: Money from tribal organization will turn facility into community health center.

By Ann Potempa, Anchorage Daily News
(Published: August 8, 2002)

After struggling without a doctor for more than a month, Whittier will reopen its medical clinic with the help of a tribal health organization. The Eastern Aleutian Tribes received federal grant money to turn the town's clinic into a community health center.

Whittier has been without a physician since July, when Dr. William Cooper resigned his position. Cooper, from Soldotna, had been making regular medical visits to the town. His departure left residents relying on emergency medical services or traveling to Anchorage for care.

To meet the town's need, city leaders joined the Eastern Aleutian Tribes in its grant application to the U.S. Department of Health and Human Services. Chris Devlin, executive director of Eastern Aleutian Tribes, said he learned this week that the grant was approved. Details still need to be worked out, but Devlin didn't expect delays in reopening the clinic. ...

Devlin said there's precedent for his nonprofit health organization helping communities outside the Eastern Aleutian region. "We have a track record of being able to help communities that are hurting with their health care system," Devlin said.

The organization operates clinics that serve all communities in the Aleutians East Borough. But it also runs a clinic in Adak, which is located on the western part of the chain and is not a traditional Native community. Adak's health care system needed help last year, and the Eastern Aleutian Tribes took control, Devlin said.

When Whittier's clinic closed and the community needed help this year, the tribal health organization applied for an annual grant that will set aside \$300,000 of federal money to operate the facility. Devlin said the new clinic will be run by a community health aide and a mid-level practitioner, which is either a nurse practitioner or a physician assistant.

Denali Commission

The Denali Commission is an innovative federal-state partnership established by Congress in 1998 to provide critical infrastructure and economic support in Alaska. Early on, the Commission designated rural health as a top priority. The Commission funds health care facilities that have completed a comprehensive plan that fully addresses both the community's health care needs and its capacity to maintain facilities in the future.

Design work is being done for new clinics in dozens of communities. The Commission is funding construction of new clinics around the state, for example, in Talkeetna, Stebbins, Scammon Bay, and Angoon and funding repairs to existing clinics in Craig, Ft. Yukon, Eyak and Pilot Point. The total investment of Commission funds for rural clinics for FY 99–FY 02 is approximately \$50 million.

WHAT NUMBERS CAN TELL US

Community health centers are funded by a federal grant program under Section 330 of the Public Health Service Act and administered by the federal Health Resources and Services Administration. The federal health center program consists of four types of health centers: Migrant, Homeless, School based, and Community. So far, most centers in Alaska are Community Health Centers. One center serves homeless people in Juneau.

Growth of community health centers in Alaska has been rapid and recent. In the year 2000, 59,355 Alaskans received quality medical care from a community health center. Anchorage Neighborhood Health Center, funded in 1974, was the pioneering community health center in Alaska. In 1995, Interior Neighborhood Health Center in Fairbanks became the second community health center in the state. Nineteen community health centers are currently funded.

In looking at your community to assess the need for a community health center, look at access to primary and secondary care. Are medical resources available in the community? Can people see someone when they feel ill? Are

there dentists? Mental health professionals and specialists in addictions? Are long, inconvenient or expensive trips needed to see these health providers?

Look at your community's population data and income data. (The applications for CHC funding require a considerable amount of data about the population to be served, and the services already available.) Sometimes health care services exist in a community, but the care is too expensive for the majority of the population. Sometimes available care is restricted to only a portion of the population, for example, Alaska Natives. When communities have populations of both Native Alaskans and Caucasians or other minority groups, community health centers may be valuable to everyone. The Native Health Corporation may be able to open a community health center that would serve the entire population, establish a sliding scale fee system for non-members, and provide needed primary care and support dental and behavioral health care.

Applicants for federal community health center grant funding are required to show that they are serving or will serve a designated Medically Underserved Area or Population (MUA/P). Staff at the Division of Public Health assist by collecting available data, completing applications and sending them to the federal Bureau of Primary Health Care on behalf of communities. As of August 2002, twenty service areas were designated as underserved for primary health care.

THINGS TO CONSIDER

What are the possible benefits of having a community health center?

Community health centers differ from traditional health care clinics in a number of ways. Community health centers focus on improving the health status of the entire community as well as the health of individual patients. Health care services are accessible to everyone, are comprehensive—including dental and mental health services, and are coordinated with other social services. In addition, community health

centers are accountable to the community by involving community members and health center users in program planning and in governing the center through a board of directors. The board is responsible for identifying community health needs, planning how to meet health needs, and evaluating the health center's efforts.

Community health centers provide high quality primary and preventive health care to everyone, regardless of their ability to pay. Health center services are not free, but patients who have no health insurance can pay on a sliding fee scale.

What does it take to establish a community health center?

Establishing a community health center is a long and complicated process. First, the clinic must be located in an area designated as "medically underserved" by the federal Health Resources Services Administration. Federal funding is competitive and you must show that services are needed. Need is related to how many people will have access to health care. Additionally, a community must be able to support its own community health center, including governance and administrative capacity. The center must be able to provide access to comprehensive health care including primary, mental, and dental health. If these services are not provided onsite, they must at least be accessible through referral networks or contract services. Community health centers must be staffed by at least one Nurse Practitioner or Physician's Assistant. The staffing level is determined by the community health center's board of directors, based on patient visits.

Is there a special way of setting up a community health center?

There is no single model of health center development in Alaska. Currently, there are 19 community health centers in Alaska serving more than 54 communities. The organizations operating the community health centers are private non-profits, Regional Native Health Corporations, and local government. Health care delivery varies from itinerant and mobile services to permanent on-site programs. Some

smaller centers are staffed by Community Health Aides and a mid-level provider, while those in urban areas are staffed by full-time physicians and dentists. Centers with patients in dispersed communities extend their reach through mobile or itinerant services.

Federally funded programs have a policy of not competing with private enterprise. The federal program strongly encourages collaboration with all the health providers in the area. Some existing clinics have converted to community health centers and retained the same providers they had before (Talkeetna, Haines, Bethel). In most areas, private providers continue to serve their same patients, while the community health center serves others who weren't able to receive care before.

Will the federal government continue to support community health centers?

The federal Health Center program has grown considerably over several decades. The program enjoys broad, bipartisan, Congressional support. Communities with federal grants can count on CHC funds as a stable, continuing source of revenue. However, if a center fails to fulfill the intent of the program, or is negligent in management, funding may be discontinued. Before funding is withdrawn, every attempt is made to bring the center into compliance.

Federal CHC funding is not flexible and must be used for the intended purpose. Good management of this funding is essential to ensure accountability to health center clients and to taxpayers. The federal government monitors management closely. Reporting requirements include quarterly financial status reports, yearly Uniform Data System (UDS) reports (program performance data), and yearly project reports.

TO FIND OUT MORE

U.S. DHHS Bureau of Primary Health Care
Community Health Centers home page
www.bphc.hrsa.gov/CHC/

For the official guidance and Requests for Proposals, HRSA Policy and Information Notice (PIN) 2001-18:
<ftp://ftp.hrsa.gov/bphc/docs/2001pins/2001-18.pdf>

Health Center program expectations:
<ftp://ftp.hrsa.gov/bphc/docs/1998PINS/PIN98-23.PDF>
Other documents may be found at www.bphc.hrsa.gov/pinspals/

Creating Health Centers
Interactive website with tools to determine eligibility and improve readiness
www.bphc.hrsa.gov/dpspnewcenters

State profile: Alaska
www.stateprofiles.hrsa.gov/1999/AK199901SP.htm

Alaska Primary Care Association
www.alaskapca.org

Alaska Primary Care Office
(907) 465-3091
www.chems.alaska.gov/primary_care.htm

Federal HRSA Field Office (Seattle)
(206) 615-2264
BCochran@HRSA.gov

Talkeetna Sunshine Community Health Center
Susan Mason-Bouterse, Executive Director
(907) 733-9214

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 5. Mental Health
Chapter 6. Educational and Community-Based Programs
Chapter 13. Oral Health
Chapter 15. Access to Quality Health Care
Chapter 26. Public Health Infrastructure

HELPING COMMUNITY HOSPITALS

In Alaska "rural" takes on a new definition. I'm not sure even "frontier" captures it either. Alaska is a case apart, its uniqueness obvious to all.

-Elizabeth M. Duke

*Health Resources and Services Administration
U.S. Department of Health and Human Services
Anchorage, April 25, 2002*

Alaska has 24 acute care hospitals, including two military hospitals and seven hospitals operated by tribal health corporations. Hospitals in Anchorage and Fairbanks serve as statewide referral facilities for providers from rural areas of the state. Alaskans often travel to hospitals in Seattle and other Lower 48 hospitals for specialty care that is not available in state.

Like hospitals in the rest of the country, the 18 small, non-profit hospitals in Alaska face rising costs, increases in outpatient visits, and decreases in the number of inpatients. Occupancy rates fluctuate, but generally average 30 percent or less of the licensed beds. Shortages of health care workers, especially nurses, make it difficult to provide care. But in addition to providing in-patient care, the small hospitals are generally a central point for health services in their communities, often including primary care, nursing home care, management of assisted living programs, and classes or programs for community residents. They are often among the largest employers in their communities. They are key components of the economy in their regions, buying services and supplies. Lastly, they provide part of the emergency response capability in rural Alaska, in coordination with emergency medical services and others.

Unlike small hospitals in much of the rest of the country, Alaska's small community hospitals face challenges that are unique to the state. These challenges are related to the local economies, geography and weather. Most of these hospitals face big seasonal fluctuations in demand for services, because of tourists, fish processors, fishing crews and other more or less transient populations who may need primary care, emergency treatment, or hospitalization. The spikes in demand are one reason these hospitals are needed, but they challenge the hospitals to budget and arrange for staffing to deal with both peak and slow times. Fixed costs are high for hospitals, for the physical plant and staffing, regardless of the number of patients seeking care at any particular time.

Weather, distance and geographic barriers like tundra, mountains and seas are always considerations affecting care decisions in Alaska. Due to the scarcity of roads connecting communities, transporting patients is primarily by air and it is expensive and time-consuming. At times weather may make transfers impossible. Small hospitals must often provide care for critically ill patients whose transport has been delayed by weather. Cost of travel also adds to the expense of recruitment, retention, and training of health care workers, and to the cost of supplies and equipment.

The Rural Hospital Flexibility Program

The federal Rural Hospital Flexibility Program (Flex Program) supports Alaska's smallest rural hospitals (and potentially some large rural clinics) to address these problems by becoming Critical Access Hospitals (CAH). Twelve Alaska hospitals are eligible for CAH designation due to their small number of beds (15 or fewer acute care beds) and their isolated locations. Hospitals with the Critical Access designation receive cost-based federal reimbursements for care for Medicare patients instead of rates set under the "prospective payment" rate system that applies to most hospitals. CAH designation may thus give a financial benefit to many Alaska hospitals.

Critical Access Hospitals are also eligible for other federal funds for new construction. Federal grant funds can be used for management consultation, training, and special projects. Critical Access Hospitals also establish relationships with larger "mentor or referral hospitals" to improve patient transfers, continuity of care, and consultations with specialists. Overall, the Rural Hospital Flexibility Program helps to stabilize small hospitals financially and assists them in improving the quality of patient care.

Hospitals participating in the Rural Hospital Flexibility Program work with the Alaska Department of Health and Social Services Office of Primary Care and Rural Health to identify needs and to decide on a planning process for system improvements. In addition to a CAH financial feasibility analysis and assessment of their financial operations, the hospitals are

expected to do community health care needs assessments and to work with their local emergency medical services (EMS) on planning for better coordination and systems improvement. The emergency medical services are also eligible for funding under the program grants for systems planning and improvement including training. The focus of this program at both the federal and state levels is increasingly on developing and implementing hospital rural health networks, improving quality of care, and improving and integrating emergency medical services into the continuum of health care services for rural residents.

A new federal grant program, the Small Hospital Performance Improvement Program, provides an additional small amount of funding to further assist the seventeen eligible Alaska rural hospitals (49 or fewer beds) to comply with federal requirements for the Health Insurance Portability and Accountability Act (HIPAA), and to improve quality of care. Activities funded under this grant program complement two of the goals of the Flex grant program (network development and quality improvement).

Through funding provided under both of these grant programs the Office of Primary and Rural Health Care and the Alaska State Hospital and Nursing Home Association are assisting several of the small, rural hospitals to create a Hospital Performance Improvement Network. Creating a healthcare database and selecting meaningful quality indicators for comparing and tracking performance will be a major focus of this network.



Valdez

"When we first looked at Critical Access Hospital (CAH) designation, it didn't look as though it would have a significant impact on us, especially since only 10 percent of our patients were Medicare eligible. As it turned out, because of the high cost of staff and high shipping costs, conversion to CAH status did make a significant difference.

"Conversion to a Critical Access Hospital achieved three things. First, it helped our cash flow. Late payments had been straining our relationship with vendors. This problem was solved by increased and guaranteed revenues. Secondly, we were able to take those increased revenues and use them to expand revenue-generating services. For example, we added physical therapy and, within 6 months, had enough new revenue to hire a physical therapy staff.

"Third, because of our CAH designation, we are eligible for special federal funds which we will use to build a new hospital, something we never could have afforded otherwise."

-Jim Culley, Hospital Administrator

Sitka

"Sitka Community Hospital was the third Alaskan hospital to convert to Critical Access Hospital (CAH) status. Financial estimates predicted revenue increases of one-half million dollars or more. Actual designation happened just when the hospital experienced the lowest volume summer in 10 years! Revamping our billing process allowed us to minimize the impact of low volume and gave us a chance to improve our billing process.

SCH has benefited from the network that was established as part of the CAH process. Sitka partnered with Providence Health Systems of Alaska in Anchorage. They give us oversight, support services, and direct support for Medical Staff Peer Review.

"Conversion to CAH status makes Sitka eligible for special federal funds that we may use to build a 15-20 bed assisted living facility."

-William Patten, Hospital Administrator

Petersburg

"One of the major differences the additional reimbursement from CAH designation has made for Petersburg Medical Center is our ability to begin to pay competitive wages to our staff.

"For the past several years, our salaries for nurses and other health professionals has been significantly lower than the Alaska average—in fact, lower than the average for hospitals in the Pacific Northwest ... CAH designation increased our revenues, and we have put these funds almost entirely into improving our wage situation. Consequently, we are now finding it easier to fill vacant positions with well-trained and qualified staff. This will improve the delivery of quality health care."

-John Bringhurst, Hospital Administrator

WHAT NUMBERS CAN TELL US

With 202 hospital beds per 100,000 population, Alaska fell far below the national average of 311 beds in 1998. As the number of elderly Alaskans increases, more hospital beds may be needed in the future.

Information on the use of health care services among public health and tribal health clients is available through the Resources Patient Management System (RPMS). There is no comparable data source for the state as a whole, since there is a mix of public and private health care providers who are not required to report activity to a single point. Unlike many states, Alaska does not have managed care organizations (health maintenance organizations, or HMOs, are a common type elsewhere) collecting utilization data on their members.

Most Alaska hospitals have recently begun reporting their discharge data. This will be useful for comparing Alaska's utilization patterns with other states, and will allow for tracking trends in hospitalizations, reasons for admission, charges, and characteristics of patients served. Hospitalizations for asthma, diabetes, and other conditions that reflect changes in health status, or which suggest need for better primary care, could then be compared to national data. Estimates of the need for rehabilitation or nursing home care could be improved by examining diagnosis codes for stroke, hip fracture, and other conditions likely to require further care.

THINGS TO CONSIDER

Are the health care institutions in your community or neighborhood working well together to serve the community? Is their strong community involvement and support?

As the hospital administrators stated, a program like the Rural Hospital Flexibility Program can help provide resources for management studies to improve efficiency, and to do community needs assessments and various other planning activities to strengthen the health care system in a region.

The Flex program requires them to ask residents their views on how services being provided are meeting community needs.

Non-profit organizations providing health services in a community or neighborhood have boards of directors or overseers who can be asked about priorities, planning efforts, or specific needs in the community.

Citizens can encourage and support their emergency medical services (EMS) organizations and their hospitals and other health programs in many ways—including working as volunteers, or being willing to serve on boards or committees. Citizens can be valuable advocates for their local health service agencies and health care providers including assisted living, home care, primary care, and health education classes when local or state policies are under consideration. They can also influence what services will be added, by sharing their opinions and needs. Being informed is the first step to being able to support the services you think your community or neighborhood needs.

Is there a clinic or hospital in your rural community that could convert to a Critical Access Hospital, or benefit from a self-assessment and community needs assessment process?

Some clinics already have 24-hour coverage for emergencies and regular visits from a doctor. If the clinic is caring for people who need more than routine outpatient treatment, such as overnight observation, or frequently has to care for people who cannot be transferred out because of bad weather, the clinic or community may want to do some local planning work to explore alternatives for providing good care. Communities can check on availability of planning assistance. In 2002, outpatient clinics are not eligible to make a direct transition to critical access hospital status, but the state's Primary Care Office is exploring the potential for such an option, or for other mechanisms for such clinics to be better reimbursed for extended care.

Is there a community health improvement process you can join?

This chapter and others give examples of community discussions and planning to improve health and well-being. These are just a few of many across Alaska. In the Matanuska-Susitna Borough, Valley Hospital has taken a leadership role in doing periodic community surveys of health status, behavior, and perceived needs and priorities. Partnerships of many kinds work on important problems like access to health care (e.g. the Kenai Healthy Communities/Healthy People Partnership, and the Anchorage Access to Care Coalition), teen suicide (Mat-Su Partnership), respite services and health education programs (e.g. the family drop-in rest area and educational stop-over at the state fair in the Mat-Su). See the topical chapters of Healthy Alaskans Volume I for links to various state resources and programs that could provide references to nearby community health improvement, health education, and planning activities.

TO FIND OUT MORE

Rural Hospital Flexibility Program
Alaska Division of Public Health
Community Health and Emergency Medical Services
(907) 465-8618 (Juneau)
(907) 269-3456 (Anchorage)
www.chems.alaska.gov/rhfp.htm

Health Facilities Licensing and Certification
Critical Access Hospital Description and Application Link
Alaska Division of Medical Assistance
www.hss.state.ak.us/dma/hflc_cah.htm

Technical Assistance and Service Center (TASC)
for the Rural Hospital Flexibility Program
www.rupri.org/rhfp-track/

Rural Information Center Health Services
www.nal.usda.gov/ric/richs

REFERENCES CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 15. Access to Quality Health Care
Chapter 26. Public Health Infrastructure

NOTES

COMMUNITY HEALTH AIDES

ALASKA'S UNIQUE HEALTH CARE PROVIDERS

"Community Health Aides and Practitioners are key to improving health status in Alaska."

-Karen E. Pearson, April 30, 2001

Community Health Aides (CHAs) and Community Health Practitioners (CHPs) are the primary source of health care for over 50,000 Alaska Natives in 178 communities. CHAs and CHPs (CHA/Ps) are not doctors, nurses, or paramedics, but health care providers trained and supported in a program that is unique to Alaska.

When antibiotic treatment for tuberculosis (TB) began in the 1950s, public health service physicians and nurses trained volunteers in villages to give the medications and to supervise the care of the large numbers of rural TB patients. Tuberculosis rates in the villages began to decrease. Some of the trained assistants began to spend part of their time on prevention of other major problems such as infant mortality, childhood diseases, and injuries.

The Community Health Aide Program was federally funded, with formal training standards established, in 1968. Today, CHA/Ps are frontline workers, the first and most crucial link in a network of care that includes field supervisory staff (experienced CHA/Ps or mid-level providers such as nurse practitioners or physician assistants), emergency medical air services, public health nurses, physicians in hub communities, small rural hospitals, and the Alaska Native Medical Center in Anchorage. (The Alaska Native Medical Center serves as the main referral hospital and provides consultation and back-up for other providers for the Alaska Native health care system in the state.)

Most CHA/Ps are Alaska Natives working in their own villages. They provide culturally appropriate care in a community they know and understand. Health aides often develop close relationships with their supervisors and referring physicians that enable them to mediate between cultures for the benefit of their patients.

It is a tough job. CHA/Ps must work closely with the village leadership to get support for the clinic. Tragedies such as suicides, homicides, and the deaths of children contribute to the stress of long hours, long stretches of on-call time, and managing emergencies hundreds of miles from the nearest doctor. Providing care to friends and family can also be stressful.

Health aides participate in all the challenges of modern health care. The number of elders with chronic diseases is increasing. The reduction in infectious diseases depends on a complex schedule of immunizations that changes every year. New drugs, new procedures, and new equipment arrive daily in remote clinics. The health aide model is now being used to train behavioral health aides and oral health aides to meet other crucial needs in Native villages.

AFHCAN

The Alaska Federal Health Care Access Network (AFHCAN) completed its overall mission for the 1999-2002 project period, linking 235 federal and state sites in Alaska in a telehealth network.

AFHCAN estimates approximately 3000 "store-and-forward" telemedicine cases completed in the prior year.

Common applications include:

- * video otoscope*
- * digital camera*
- * digital ECG*

Telepsychiatry is used regularly by the Alaska Department of Corrections—Anchorage-based psychiatrists and a psychiatric nurse practitioner have video and voice visits weekly with 25 to 30 patients a week. The patients are located in correctional facilities in Seward, Fairbanks, Ketchikan, Juneau, Kenai, Bethel and Nome. Kotzebue was to be added to the list starting in September 2002.

Gateway Mental Health Center in Ketchikan, Bartlett Memorial Hospital, and Alaska Psychiatric Institute and Maniilaq Medical Center also have telepsychiatry programs.

-Alaska Telehealth Advisory Council 2002 Annual Report

CAREER REFLECTIONS

Edna Charley described her career as a Community Health Aide Practitioner shortly before her retirement in May 2002:

“It was 1976 and the health aide program was just getting started in Glennallen. They needed somebody and they knew I had been a nurse. My kids wanted to move up there. They grew up in Anchorage, but they liked village life. So I agreed to do it.

“There was no clinic. I worked out of my house and out of my car. All we had was a little cabin. I just moved into that little cabin and all my medicines were in that little black bag. I kept it in my trunk. That was the only safe place to lock it up.

“Chistochina is a tiny village—33 people. I’d call the kids in for fluoride treatment, do home visits and take blood pressures. I was on the village council, too, so I kind of pushed for a clinic. We took one of the older houses there and got some money to fix the inside. There was no running water and no sewer. The heat was propane. No refrigerator, but it was cool enough in there we didn’t need one. I liked it, but because it was on the highway system, a lot of people went to the doctor. It wasn’t that much of a challenge. But I got promoted and became a health aide supervisor.

“I moved back here to Kake, my hometown, October 6, 1987. It was a major change. Having 700-800 people here, more in the summer. When I first came I was the only health aide. But we had real good docs. They were supportive of the health aides. I appreciated that because I’ve worked where they weren’t supportive, where they question your abilities and your knowledge. It means a lot to me that I’ve had that support.

“Moving to the village to be a health aide, I had to learn the political part just to get a clinic. I was involved in the village council. I was on the health board, service unit board, and Native health board. And then, AFN (Alaska Federation of Natives), too. I learned all about communication. I enjoyed that. I was on the city council for a while, too. Always with the same direction: health and safety.

“I like the direct patient care. I resisted stuff like the computer. I didn’t like the idea of patient information being on there. But it really helped.

“The equipment—the digital camera and video otoscope—helps a lot. Being able to get directions right away from the doctors. They get it and call us right back. Helps a lot and saves traveling money. And the polycam. It’s like a TV where you can have a meeting and camera and everyone can talk. It’s not delayed and it’s not jerky. It’s live; it’s really nice. We use that for getting directions on patient care.

“The major changes are the technology. I was thinking about that little black bag, the old-fashioned doctor’s bag. We have a lot more drugs. You could never carry them in the old black bag! We have a lot more vaccines, and the schedule is always changing. We have x-ray. There’s a lot to learn. Our manual used to be a little yellow book. Now it’s three books. Another difference is getting more dental care here. That’s what we do, too—we point out what we think we need, like the increase in dental care.

“I think what really helped me was having the doctors being supportive and having confidence in my ability. Makes a big difference. And then the staff here, we get along and we’re supportive of each other. And we laugh a lot. Many things to laugh about! I think my own personal faith is what kept me going. And, it just happens that the staff here, too, has strong faith and we draw on each other a whole lot. My grandchildren help a lot, too. They help you realize life goes on.

“The part I like, besides the direct patient care, is the education and prevention. The ‘Kids Don’t Float Program,’ the ‘Peacemaking Circle.’ We used to go to the school to give health education, sex education, that kind of thing. I think it is a major part of our job.

We try to influence the health, the well-being of the community. We started community clean up. It still goes on. We did a diabetes screening—went door to door. They wouldn’t come to the clinic. When I came we had three diabetics. Now there are 28. That’s a shift, too. But I think we are making people become more aware of those kinds of things. That’s our responsibility, not just taking care of the cold or the laceration.

We pushed for the swim program, too. That’s going on this summer. It only makes sense. We live right here, by the water. If people are fishing for salmon, they are on the water. We’re lucky that nothing’s happened, but we don’t want to wait for something to happen.

“We have to be role models, too, as well as teachers. It doesn’t make your work very strong if you aren’t living it yourself. You can’t just preach about things, especially in small communities. You can’t teach about alcohol abuse if you’re abusing it yourself. We are involved with the Healing Heart Circle, something positive in town.

“I think the health aides, the ones who hang in there, are the same kind of people who are involved in the community. You have to know all that, what’s going on in the community. We have to know our community pretty well.

“Having the self-determination for the tribe, and being responsible for our own healthcare, have made a big difference. When I grew up here, there was nothing. I remember suffering with ear infections, toothaches. Most of the babies were born here. Big difference. Not that long a time, really. One lifetime.”

Kids Don’t Float (KDF)

Between 1990 & 1998, the drowning rate in Alaska was two and a half times the national average. The Kids Don’t Float program began in the Katchemak Bay area in 1996 in response to the high drowning rate among children there. The pilot project focused on water safety education and supplied 15 life jacket loaner boards around the bay.

In 1997, the Coast Guard and ISAPP collaborated to extend this life saving courtesy throughout Alaska. Today there are over 300 sites by rivers, lakes, and bays. There are six documented cases in which children were likely prevented from drowning because of a KDF loaner vest.



PFD Otter says, “Kids Otter wear a life jacket while playing in or near the water!!”

*[www.chems.alaska.gov/
kids_don't_float.htm](http://www.chems.alaska.gov/kids_don't_float.htm)*

WHAT NUMBERS CAN TELL US

Approximately 500 Community Health Aides (CHAs) and Community Health Practitioners (CHPs) work in rural Alaska (300 and 219 respectively). These providers have approximately 300,000 patient encounters per year. In addition to staffing and managing their individual clinics during regular office hours 5 days a week, CHA/Ps respond to medical emergencies 24 hours per day, seven days per week, 365 days per year.

Primary and emergency care for approximately 50,000 Alaska Natives is delivered at a cost of \$900 annually per patient or \$150 per patient visit.

Attrition rates for CHA/P have ranged from 12 percent to 33 percent a year since 1987. Attrition rates increased 8 percent from 1993 to 1999. Stress and burnout account for a significant part of the loss of this health care workforce.

The number of village-based clinics increased from 140 in 1970 to 178 in 2001. The Denali Commission is targeting rural communities in an intensive clinic building and renovation program.

Most villages served by CHA/Ps have between 101 and 500 residents.

Distribution of CHA/P Clinics by Size of Village

<i>Population</i>	<i>Number of Clinics</i>	<i>Percent of 178</i>
<i><100</i>	<i>37</i>	<i>21</i>
<i>101-500</i>	<i>102</i>	<i>57</i>
<i>501-1,000</i>	<i>36</i>	<i>20</i>
<i>>1000</i>	<i>3</i>	<i>2</i>

Source: Community Health Aide Program Update 2001, Alaska Board Tribal Health Directors, February 19, 2001.

THINGS TO CONSIDER

“For over thirty years, local Native CHA/Ps have been delivering primary health care to the people in their remote villages. CHA/P services are a sustainable, effective, and culturally acceptable method for delivering health care. CHA/Ps provide health care with a continuity that could not be matched by any other providers who would move in and out of the villages.” (*Community Health Aide Program Update 2001*, Alaska Native Health Board, Association of Tribal Health Directors, February 19, 2001. p.19.)

Several communities with mixed Alaska Native and non-Native residents have community health aide clinics. Those clinics using Denali Commission or federal Community Health Center funding will serve patients regardless of status as Indian Health Service beneficiaries. Communities without a CHA clinic that have an interest in developing a similar service can inquire of the Alaska Division of Public Health Primary Care and Rural Health Office about progress in developing arrangements for similar services.

TO FIND OUT MORE

Alaska Community Health Aide Program
www.akchap.org

Primary Care and Rural Health Office
Alaska Division of Public Health
(907) 465-3091
www.chems.alaska.gov/

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME 1

Chapter 6. Educational and Community-Based Programs
Chapter 8. Injury Prevention
Chapter 7. Health Communication
Chapter 13. Oral Health
Chapter 15. Access to Quality Health Care
Chapter 18. Immunizations and Infectious Diseases
Chapter 23. Diabetes
Chapter 26. Public Health Infrastructure

A SAFE HARBOR IN HARD TIMES

AN ANCHORAGE MOTEL STORY

"Simple works, basic humanity works, fun works, normal works. One guest described the motel as 'sort of a cross between Fawlty Towers and Cheers without the booze.' I just love that."

-Lynne Ballew

Homelessness is a problem throughout Alaska, but perhaps more visible in Anchorage than in smaller communities. People become homeless for all sorts of reasons—job loss, family problems, unexpected medical bills which drain their resources, physical or mental disability or addiction, for example. No matter what their problems or the numbers of agencies helping them, people need housing. A place of your own makes all problems more resolvable. When that home, even a temporary one, also supplies assistance and humane and dignified support, individuals and families are in a better position to reassert control over their lives and their health.

Communities can improve public health through attention to the housing needs of their residents. Concentrated effort and creative thinking may be needed to find an approach that will work for your community or neighborhood, whether the need is for more affordable housing, short-term assistance, or a combination of supportive services.

In the following story, Lynne Ballew describes two years of effort to create the Safe Harbor Inn. Lynne Ballew, a single parent and former welfare mother, housing specialist and community activist, moved to Anchorage in 1978 to found Bean's Cafe, a social center and free restaurant for homeless people.

THE SAFE HARBOR INN: AN OVERNIGHT SUCCESS

by Lynne Ballew

Background

Up through the 1970s, if you were on the road or between apartments or just down and out, where did you stay? Most likely answer: At an inexpensive motel or a boarding-house. At a Holiday Inn (they were the first in the genre of budget lodging, remember?). At a Motel 6 (because they cost \$6 a night). At a Super 8 (because they cost \$8 a night). Or, even better, at a mom-and-pop stucco-and-log place that smelled of Clorox, whose TV got maybe two channels, whose coffee was appalling, and whose owners were friendly and happy to see you.

What happened to this incredible resource? The chain motels up-scaled. The private motels increased their prices because they could. Zoning policies and gentrification everywhere sharpened the divide between commercial and residential areas, and a significant housing resource for thousands of Americans, the cheap motel and the boarding-house, essentially vanished. The result was thousands of homeless people.

Remembering what a simple, inexpensive, and congenial form of lodging America once had in virtually every community, we decided to bring it back to Anchorage—to reinvent the cheap motel, but to tailor its operation and its target guests to fit contemporary needs.

Why Anchorage?

On any given day in Anchorage, approximately 1,000 homeless people have no safe, secure, affordable place to stay where they can begin to get back on their feet. Like every other city of its size, Anchorage has faced a longstanding gap in housing resources that can help homeless families and individuals with disabilities make the transition from shelters or the street to permanent housing.

Galvanizing

We incorporated Anchor Arms, Inc. (AAI) in December 1999 as an Alaska nonprofit corporation and soon received our 501(c)(3) not-for-profit determination from the IRS. We built a board of directors of senior professionals from business, the hospitality industry, law enforcement, and social services (not surprisingly, the average age of board members is well over 50). The board has worked with hundreds of community representatives to raise funds (more than \$1.23 million to date), garner widespread community support, collaborate with local agencies that serve homeless people, negotiate the motel purchase, and refine the motel business plan.

On October 15, 2001, AAI purchased a newly renovated 30-unit motel in east downtown Anchorage (the former Grizzly Inn), and the Safe Harbor Inn opened for business on November 9, 2001.

Immediate results—it works!

The Safe Harbor Inn was an overnight successfull five days later-and has remained full. Through April 30, 2002, 162 guests have been provided with 6,131 bed nights. Of these guests, one-fourth have been persons with mental disabilities (who have been provided with 1,872 bed nights), nearly three-fourths have been families, one-third have been children under 18, and 10 percent have been persons with physical disabilities. Half of all guests have been minorities, with 30 percent Alaska Natives/American Indians. Ten rooms are set aside for guests with mental disabilities; in addition, agencies have pre-reserved five rooms for homeless families, one for victims of sexual assault, and one for homeless Veterans. Five

of the motel's 30 rooms will soon be handicap accessible.

Of guests who have checked out as of April 30, 2002, 66 percent have moved into permanent housing—a remarkable success rate. Our goal is that as many of our guests as possible will benefit from their lodging at the Safe Harbor Inn, get back on their feet, and move on to permanent housing situations.

Motel rooms are not provided free of charge. The 30-day rate is \$375, and can be paid by the guest, the referring agency, a third party, or a combination of sources. Guests typically have used their stay at the motel to save up for an apartment, get a good reference from motel management, and secure employment and permanent housing. In short, the Safe Harbor Inn is providing them with a critically needed stepping-stone to self-sufficiency—not a handout.

The motel's waiting list continues to grow—60 persons as of this writing. Guests, referring agencies, and stakeholders all agree that the Safe Harbor Inn needs to expand as soon as possible. More than 40 agencies now have memoranda of agreement with Anchorage Arms, Inc. in place or in process to refer clients to the motel. AAI is now beginning another capital campaign to build 25 additional units on the motel property.

How it works

AAI's mission is to provide comfortable, safe, affordable, well-managed temporary housing for low-income persons and families who are referred by, and clients of, social service, nonprofit, and civic organizations in Alaska. The Safe Harbor Inn is a motel—not a social service agency, not a “program,” not a care facility, not an institution. Our guests are guests—not “clients,” not “residents,” not “tenants,” not “cases.” Our watchwords are privacy, dignity, respect, warmth, and friendship.

Because being safe, warm, clean, well-rested, well-fed, and welcome are integral to getting back on your feet, every fully-furnished, attractive room has a full bath, cable TV, coffeemaker, microwave, refrigerator, and motel

goodies. The office is open 24/7 with free coffee, food, phones, and helpful, jolly staff. Security staff are present 24/7, and house rules are strictly enforced for the benefit of all guests. No alcohol is allowed on the premises and no smoking is allowed inside the buildings. Four staff are veterans; three are formerly homeless; and two are former guests of the motel.

Guests come by referral only (no walk-ins) from local agencies, which provide all treatment and support services. Guests must have incomes below 50 percent of median income (using U.S. Department of Housing and Urban Development (HUD) guidelines), must continue to receive services from their referring agency for the duration of their stay, must be unable to afford another place to stay, and must be likely (in the referring agency's judgment) to be responsible guests. There is no maximum length of stay (this is up to the referring agency). So far, all guests have met HUD's definition of "homeless." Through April 30, 2002, the average length of stay among guests who have checked out was only 33 days.

Problems we encountered

Seller nightmares. Our first attempt to purchase a motel—the Anchor Arms Motel (hence our corporate name)—fell through after a year of negotiations when the motel's owners simply walked away from the transaction. Our second attempt also took nearly a year and was no less grueling. We persevered.

Funding issues. Our motel model, simple and effective as it was, did not fit the criteria of the two most obvious sources for funding transitional housing—HUD and the Alaska Housing Finance Corporation—because it was commercial rather than residential, was lodging rather than rental housing, and had no maximum length of stay. The Safe Harbor Inn's simplicity and potential, however, proved compelling enough to receive significant funding from the Alaska Mental Health Trust Authority, the State Department of Health and Social Services, the Rasmusen Foundation, and dozens of private businesses, banks, associations, and individuals. While raising funding from so many sources meant a lot more work, this breadth of support

has served to increase the motel's general popularity and community acceptance—probably far more than a single public funding source would have.

Problems we didn't encounter

Zoning and NIMBY. Because we bought a motel and kept it a motel, we had no conditional use, zoning change, or other public processes to go through, which shortened our development time considerably. And because the motel is located in a commercial/industrial area across from Merrill Field, and had suffered from years of questionable ownership and operation when it was the Woods Motel and the Grizzly Inn, we have had no NIMBY ("not in my back yard") problems whatsoever. One of our neighbors - Six States Distributors - even plows our driveway for free. Our plans for landscaping, fencing, and property enhancements will clearly help to improve the neighborhood.

Building quality. Fortunately, the motel we purchased already had 25 completely renovated units, two of which are still being used as a temporary office. A separate building with a new office space, guest laundromat, and five more units is now being finished out for handicap access (it was down to studs when we purchased the property). But no major systems had to be replaced, and the main building is fully sprinklered. A giant overall rehabilitation project would have increased our timeline and costs substantially.

Duplication of other nonprofits' programs. We very carefully designed our project and services to be responsive to, and not competitive with, the needs of local service provider agencies and their clients. Referring agencies have been thrilled with the resource the motel provides for them and their clients and are impatient only with the length of the waiting list. Nor are we competing with other agencies for municipal or federal housing funds.

Operating problems. Surprisingly, we have had very few behavior problems with guests in our first six months of operation. Of the 11 terminations to date, most were for smoking in the rooms. We attribute our peaceful atmosphere

Safe Harbor Residents Say:

"I don't know of another place that can come close to what the people have done for me and the rest of the people here."

"When you hit rock bottom, and you find a place like this, it gives you a sense of direction back to normal living."

"All our needs were met and it was a great place to be during our transition into regular housing, and back into life, so to speak."



Emma Mattson-Semonis and her class at Anchorage's Wendler Middle School were honored for gathering an enormous quantity of toiletries, gifts and holiday decorations for the guests of the Safe Harbor Inn.

2001-Spirit of Youth

to our extremely friendly and helpful staff, to appropriate referrals and support from our referring agencies, to the fact that all guests agree to the house rules before they come, to the comfort and amenities of our rooms, to our 24/7 security, and to the scarcity of other lodging resources. Our models for guest services are the Marriott and Sheraton—and guests have responded in kind, with helpfulness and respect for the staff and for each other. Our culture and our customer service standards are firmly in place and will be strictly maintained.

Physical atmosphere. Much of the Safe Harbor Inn's success is due to its attractiveness—log siding and green shingles on the exterior and new rooms with all the amenities. Guests routinely gasp when they are shown to their rooms. They don't expect lovely new furniture, huge windows, a 25" cable TV with remote, coffeemaker, hair dryer, refrigerator, microwave, full bathroom with a new rubber ducky on the tub, fresh supplies of coffee, tea, shampoo, soap, toothpaste and toothbrushes, tablets and pens in the desk, or the chocolates on the pillows. Beautiful surroundings are vital to everyone's well-being and recovery. Our guests deserve no less.

Outlook for the future—expansion and replication

Building 25 more units will not only help us continue to meet our housing goals by serving more guests but will enable us to meet our financial goal of self-sufficiency. It is our goal to cover all operating expenses (between \$250,000 and \$300,000 per year) with revenues from room and laundry charges and a small component of private donations. With the addition of one more security staff, the motel staff now on board will be sufficient to manage the additional units.

Our experience to date tells us that the new building should include several larger units for bigger families, more handicap units, and a good-sized common area with computers and workspace for guests. We believe we can raise most of the estimated \$1,875,000 total development costs (\$75,000 per unit) from Alaska sources for a new building. Our task is easier because of the overwhelming public support for the Safe Harbor Inn, our ability to document the need for the new building, and the relative ease of constructing a new facility with few site improvements on clean land that we already own.

We do not know of any similar organizations or of other nonprofit motels like the Safe Harbor Inn. We do know, however, that there are modest motels for sale, homeless people, service agencies, and community resources throughout the U.S. We believe that the Safe Harbor Inn model is ideal for replication in other communities nationwide, and such replication is one of the five major goals of our strategic plan.

We are now getting inquiries from other communities about the motel and are providing them with technical assistance. Beginning in fall 2002, we will develop a comprehensive how-to manual and a Website that can assist other communities in developing their own Safe Harbor Inns.

SAFE HARBOR INN PARTNER AGENCIES (AS OF APRIL 30, 2002)

The following agencies have signed Memoranda of Agreement with Anchor Arms, Inc. to refer their clients to the Safe Harbor Inn:

Veterans Administration/VA Social Services	Salvation Army - McKinnell Shelter
Abused Women's Aid in Crisis (AWAIC)	Southcentral Foundation
Cook Inlet Tribal Council Transitional Services	American Cancer Society
Department	Anchorage Housing Initiatives, Inc.
Bean's Café	UAA Adult Learning Center
Brother Francis Shelter	Fort Richardson Post Chaplain's Office
Office of Public Advocacy - Public Guardian	Municipality of Anchorage Workforce
RuralCap - Homeward Bound	Development
Lutheran Social Services	Cook Inlet Tribal Council Family Services
Alaska's People, Inc.	Department
Catholic Social Services	NineStar Enterprises, Inc.
Anchorage Neighborhood Health Center	Anchorage Mental Health Court (in process)
Alaskan AIDS Assistance Association (Four A's)	Stone Soup Group (in process)
Providence Alaska Medical Center	LifeQuest (in process)
Salvation Army Clitheroe Center	Alternatives Mental Health Center (in process)
Mary Magdalene Home Alaska	Division of Family and Youth Services (in
Anchorage Center for Families	process)
Standing Together Against Rape (STAR)	Mabel T. Caverly Senior Center (in process)
Access Alaska	Division of Vocational Rehabilitation (in
Southcentral Counseling Center (accounts for	process)
28% of referrals to date)	Alaska Native Medical Center (in process)
Alaska Psychiatric Institute	Anchorage Probation and Parole (in process)
Recovery Connection	Division of Adult Public Assistance (in process)

WHAT NUMBERS CAN TELL US

Estimating the number of homeless people in any community is difficult. Some people may not be willing to tell anyone that they are homeless. It may be possible to count the clients in shelters and food kitchens, but many others may live in cars, rural campsites, parks, abandoned buildings, or other locations. People moving from house to house staying with relatives or friends may be considered to be homeless as well, but are unlikely to appear in any count. Other homeless people, who receive services from several different agencies, could be counted several times over.

The U. S. Census Bureau attempted to count people living in shelters, campgrounds, and on the street in the 2000 census. Because of the many problems involved in counting the homeless, however, the Census Bureau does not release any figures on the homeless population.

The Alaska Housing Finance Corporation carries out the Homeless Service Providers Survey twice a year to gather a "point-in-time" estimate of people receiving services from agencies that serve the homeless. In July 2001, 118 agencies were contacted, and 62 (52%) responded. Their findings are not a census of Alaska's homeless population. In the July 2001 count, almost 1,500 persons were identified as homeless. The largest numbers were reported in Anchorage (889), Fairbanks (112), and Juneau (294).

***Alaska Family Hospice:
Home for Rural Alaskans
Visiting Anchorage for
Healthcare Services***

Since 1997, the Alaska Family Hospice has provided affordable housing for rural Alaskans visiting Anchorage for health care services and training. The apartments have given temporary housing to over 22,000 individuals and families, including community health aides in training and families of patients at the Alaska Native Medical Center, in an alcohol free environment and in a safe neighborhood. Each apartment has a kitchen; grocery list pickup and delivery is available. A shuttle bus service connects the apartments with the airport and major medical centers. Extended stay health care clients are provided with temporary employment opportunities. Yup'ik speakers are on staff. Four Alaska Native women are the current owners of the apartments. Their ownership was arranged through a Welfare-to-Work owner-management training program and small business grant.

Overcrowding may be less noticeable than homelessness, but overcrowding is a frequent problem where affordable housing is limited. Doubling up of families and sleeping in shifts in crowded apartments can contribute to poor health because of stress or poor sanitation. Schoolteachers, public health nurses and community health aides may be the first to see evidence of such problems. Counts may not be available, but “key informants” involved in community housing, health, mental health services, and school systems may have considerable information about the situation, if they pool what they know.

THINGS TO CONSIDER

How important is housing to health?

Having a home is basic to health. Homeless people are less able to practice basic sanitation and food safety, less likely to have access to telephone for seeking employment and support services, and less able to prevent injury and violence. They are more likely to become ill. When they become ill, their health needs are less likely to be attended to. They are less likely to have prenatal care, and their children are less likely to have such preventive health care as immunizations. Affordable housing helps solve homelessness. Affordable housing promotes personal and public health.

The people who find housing at Safe Harbor Motel are diverse, but they share one characteristic—they lack housing. Some may be victims of domestic violence, for example, while others may have had financial reversals. What they share is trouble finding housing they can afford. Safe Harbor gives them a temporary affordable home, while they work out long-term solutions. Safe Harbor is not about treatment for diseases or conditions. It is, therefore, more difficult to link it with chapters in *Healthy Alaskans 2010, Volume I*. Instead, we have listed “Health Promotion” as the concept to which it is related. Safe and affordable housing supports public health.

How is your community solving temporary shelter needs?

Alaska has many resources to deal with temporary and permanent housing needs: the Alaska Housing Finance Corporation, regional Tribal Housing Authorities, the federal Department of Housing and Urban Development, the Alaska Homeless Coalition, and many groups interested in housing for special populations in need of housing assistance, for example, seniors and people with developmental disabilities.

These resources can help you identify housing needs in your community. If a community has a significant homeless population, or people moving into and out of the community because they can't find affordable housing, or not moving back after time in institutions because affordable housing isn't available, or if there's too much overcrowding because people can't afford homes of their own, housing programs may help you to solve these problems. The Safe Harbor Inn solves these problems by combining functions that are separate in some communities: domestic violence shelters, veterans' housing, and transitional housing for people with special needs.

TO FIND OUT MORE

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(907) 868-7373
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Alaska Housing Finance Corporation
1 (800) 478-AHFC
(907) 330-8447
www.ahfc.state.ak.us/

Alaska Coalition on Housing and Homelessness
(907) 277-1731
www.akcoalition.com

Anchorage Safe City Program
The LINK Project
(907) 343-4876
www.muni.org/health2/link.cfm

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 5. Mental Health
Chapter 6. Education and Community-Based Programs
Chapter 9. Violence and Abuse Prevention
Chapter 15. Access to Quality Health Care
Chapter 26. Public Health Infrastructure

NOTES

SPIRIT OF YOUTH

ENERGY FOR A BETTER ALASKA

*"Alaska youth are extraordinary."
-Spirit of Youth Foundation*

Spirit of Youth is an Alaskan non-profit group dedicated to creating and promoting opportunities for youth involvement in their communities by building leadership and by providing media recognition for the positive contributions youth are making statewide.

Spirit of Youth began in 1997 as a media-based project to address the growing negative image of teenagers. Since then, hundreds of positive stories about Alaskan youth have spread through television, radio and local newspapers. An annual banquet honors the contributions teens are making in 10 categories of activity.

Below are some of the 2002 winners.

SPIRIT OF YOUTH 2002 WINNERS

Heather and Hanna Craig, Science and Technology Winners

The Science, Technology, and Media award recognizes youth who pursue science or technological endeavors for the education of others, safety, or fun. It also includes teens' involvement in all forms of media from newspapers, radio and TV to creating public information materials, like posters, or pamphlets.

Heather and Hanna Craig, sisters and seniors at East High School, Anchorage, have taken their love of robotics to new heights. Together they invented the one and only "Ice Crawler," a true Alaskan, lifesaving robot. Its job is to rescue people trapped in the ice, whether they have fallen into a glacial crevasse or into the freezing waters of a winter lake. The 20 pound robot is designed to cross rigorous winter terrain and deliver a lifesaving line to the victim. The "Ice Crawler" is maneuvered by the rescuer through a tether that does double duty as an electrical connection and a rope to tow the person to safety. The sisters mastered the multiple challenges of design and construction to develop a prototype that has won national awards. John Pursey, owner of Envision Product Design, stated, "There is nothing else like it; you would think the rescue industry, with its variety of tools to save people, would have something like this, but they don't!" Heather and Hanna hope that with additional funding the Ice Crawler prototype will become a reality to help save many lives in the years to come.

Aniak Dragon Slayers, Life Savers and Prevention Winners

The Spirit of Youth Life Savers and Prevention category salutes teens who have surpassed "the call of duty" by preventing injuries and saving lives.

The Dragon Slayers are a squadron of girls between 13 and 20 who are doing extraordinary life saving deeds for their community. This group began in 1993 when the volunteer fire department broadened its mission to include emergency medical services. The average call volume immediately shot from 20 a year to more than 250. Pete Brown, the fire and police chief, stated, "Clearly we needed help! So we turned to our teens."

Youth members begin as “fire-flies.” They must undergo over 100 hours of fire and first aid training. After another 140 hours of training, the “dragon slayers” can perform basic EMT functions. Squadron members wear beepers so they can respond to emergencies, day or night. Their calls range from fighting fires (sometimes being the first on the scene) to tending critical care patients often unreachable by plane or road.

One call was 17 hours long. A victim of a head-on collision who had a fractured skull and punctured lung required stabilization. He was 3 1/2 hours away by boat, at night, in the fog. The girls worked through the night without food, stabilized the man, and he recovered. Clearly the Dragon Slayers are one of the Aniak’s greatest resources, as well as role models for other youth.

Britanee Rayburn, Overcoming Challenges Winner

This category salutes youth who display exceptional determination and stamina as they overcome significant life challenges.

Britanee, a junior at Anchorage’s Dimond High, has proved to be an amazingly strong person. After the tragic death of her sister due to domestic violence, Britanee took the initiative to write a true-to-life report. She made many presentations that include pictures, a video and resources for anyone needing information on domestic violence. Britanee hopes that by telling her sister’s story she will help others who are in abusive relationships. Her focus is to get the message out: abuse is not to be taken lightly. Eventually, she would like to work in the field of domestic violence prevention. Spirit of Youth believes that Britanee’s courage and commitment opens others’ eyes to this often ignored situation.

Homer Skateboarder Association, Award in Government

After being banned from parking lots all over town, a group of young men formed the Homer Skateboarder Association. The group has a single purpose: to create a skateboard park in Homer. They knew that many businesses and school administrators viewed them as nothing more than “skate punks”. With the advice of some savvy adult mentors, and under the direction and leadership of co-presidents Eric Szymoniak and Ivan Heimbuch, some 40-50 students took on this cause and faced the opposition. The group did their homework—wrote letters to the editor, gathered signatures on petitions, researched and created a “white paper,” and attended and testified at numerous local council and parks and recreation committee meetings. Through various fundraisers, such as car washes and a concert, they managed to bring in almost \$5,000, enough to contract with a consultant to work with them on best designs for a skateboard park.

The group learned first hand how to follow the public process and managed to convince the city to donate a site for the park. Homer resident Annie Moyland stated, “These teens have helped change the way people in this town, until now, have viewed skateboarders.” The selected site is an old cracked basketball court that needs work, but with volunteers from the community, they hope to see their dream become a reality during the summer of 2002.

What makes for a successful teen program?

As you think about programs and services for teens, “Critical Elements of Successful Youth Programs” (in Adolescent Health Plan) can be a helpful tool. Extensive research on prevention programs targeting teenage substance use, tobacco, violence, pregnancy and school failure has identified critical program components for successful outcomes. The more these elements are incorporated, the more likely your teen programs will be successful. Some of these critical elements include:

1. When the program is staffed, staff encourages youth to do things they are capable of doing themselves—instead of doing things for them. Staff are respected, trusted and well liked by youth. Staff see youth as resources and have high expectations of all teens. Staff set rules and establish clear expectations for youth behavior.
2. Strategies are based on research, and are locally driven. Strategies are modified according to individual needs (identify youth who need extra support, provide or refer what is needed.) Strategies involve parents, extended family members and or significant adults in teen’s life. Strategies actively involve youth as the planners, doers, evaluators—not just as recipients! Activities have elements of fun and challenge. Strategies are evaluated and modified, incorporating ongoing feedback from youth and families. Successes are recognized along the way!

When planning your youth efforts, remember, all youth need:

- Safe, secure, supportive, welcoming environments.
- Time spent with caring, respectful, supportive adults, who expect the best.
- Time for sincere, trusting relationships to build.
- Multiple opportunities to be actively involved.



Photo Courtesy of James Poulson
From "Spirit of Youth: No Loitering"

Spirit of Youth: No Loitering

by Ellen Frankenstein

NO LOITERING is an intimate portrait of teenagers trying to understand their world and their possibilities. The film weaves together video shot by teens and by the filmmaker, as they work together to make a film and create expressive outlets for youth in the community. They organize dances and community events and paint a mural. At the same time, with humor and pathos, these young people raise issues around violence, feeling misunderstood by adults and lacking respect in their community. Set in the small town of Sitka, Alaska, home to a large Native American population, the video chronicles the creativity, concerns and dreams of youth growing up today.

www.newday.com/films/No_Loitering

**New Day Films
(201) 652-6590
www.newday.com**

WHAT NUMBERS CAN TELL US

What do we know about the health of adolescents in Alaska? How can you find out about the health of adolescents in your own community? In addition to the developmental assets model, which attempts to measure strengths and resilience, researchers use health indicators from statistics and surveys to learn about adolescent health.

	Adolescent Health Indicators	Alaska	U.S.
1	<i>Students in grades 9–12 who have used any tobacco product in the last 30 days:</i>	39%	40%
2	<i>Students grade 9–12 who have used alcohol, marijuana, or cocaine in the past 30 days:1999</i>	51%	54%
3	<i>Violent death rate, age 15 to 19: 1999 Suicide, unintentional injury, homicide, and unknown intent (rate per 100,000 population)</i>	86	53
4	<i>Suicide rate, age 15 to 19: 1999 (rate per 100,000 population)</i>	41	8
5	<i>Young teen birth rate: 1999 (live births per 100,000 girls age 15-17)</i>	27	29
6	<i>Teens 16 to 19 who drop out of school: 1999</i>	8%	10%
7	<i>Teens 16 to 19 not in school and not working:1999</i>	10%	8%

Data sources:

1, 2: Youth Risk Behavior Survey (YRBS). The Alaska sample for 1999 did not include Anchorage. Alaska data for 1999 are weighted and are representative of the state student population excluding Anchorage.

3, 4, 5: Alaska Bureau of Vital Statistics and National Center for Health Statistics

6, 7: Kids Count 2002.

THINGS TO CONSIDER

What can we learn from Spirit of Youth?

Spirit of Youth reminds us of the many positive contributions youth make to our communities. Research shows that making a contribution to others is an important part of growing up healthy. Recognition of such contributions may also help encourage more constructive activities. Communities or agencies can look for positive things youth are currently doing, share those stories with local media, and recognize youth who are doing positive things at public events. Submit positive youth stories to www.spiritofyouth.org for further recognition and media coverage.

What's the idea behind Spirit of Youth?

“Youth developmental assets” describe those parts of children’s lives that help kids succeed—the building blocks in children’s lives that help them grow up strong, capable, and caring. Children who have positive experiences in their lives avoid such negative behavior as substance abuse and early sexual experimentation. Youth developmental assets are described in *Helping Kids Succeed - Alaskan Style* by the Association of Alaska School Boards and the Alaska Division of Public Health.

Spirit of Youth Foundation incorporates youth participation and what is known about encouraging healthy behaviors into all phases of its planning, implementation, evaluation as well as governance. These and other activities are discussed in the Department of Health’s Adolescent Health Plan which describes what families, schools, community members, local agencies and policy makers can do to contribute to adolescent health and well-being.

What are other groups doing?

Local organizations in many communities across Alaska have adopted the Developmental Assets framework and have adapted their programs to include asset building practices, policies, and services in many ways. Some school districts are using the developmental assets framework to determine what activities and projects to support. Youth are involved in some local agencies' boards of directors, serve on municipal advisory commissions or serve as committee members for program planning, delivery, and evaluation. Regional organizations sponsor youth-adult partnerships to address community identified needs.

A recent example is a six-year statewide youth development initiative known as AK-ICE (Alaska Initiative for Community Engagement). The project is jointly managed by the Association of Alaska School Boards and the Department of Health & Social Services. Alaska-ICE emphasizes our shared responsibility for preparing Alaska's children and youth for the future, including their academic success, civil behavior, racial tolerance and reduction of risky behaviors. AK-ICE is based on the Association of Alaska School Board's 1991 long-range plan and their 1998 book, *Helping Kids Succeed - Alaskan Style*. This book is based on the Search Institute's Developmental Assets framework and ideas provided by thousands of Alaskans. It provides tools and suggestions for building "assets" or protective factors among Alaskan youth. AK-ICE provides local, regional and statewide training, technical assistance, demonstration projects, coaching and resources to schools, community organizations, parent groups and faith communities.

Alaska 20/20 regularly includes students regularly in conferences and in planning activities to look at priorities for Alaska's future.

TO FIND OUT MORE

Spirit of Youth Foundation
(907) 566-7676
(907) 269-3425
www.spiritofyouth.org

Adolescent Health Plan:
www.hss.state.ak.us/dph/mcfh/default.htm
(907) 269-3425

Alaska Initiative for Community Engagement
Alaska-ICE
(907) 586-1486
www.alaskaice.org

Search Institute - Development Assets
www.search-institute.org/

Adolescent health indicators for Alaska:

The Youth Risk Behavior Survey (YRBS)
Division of Public Health
Section of Epidemiology
School Health Program
www.epi.hss.state.ak.us/programs/chronic/school.stm
(907) 269-8000

Kids Count Alaska 2001
Institute for Social and Economic Research
www.kidscount.alaska.edu
(907) 786-7710

Alaska Bureau of Vital Statistics
Division of Public Health
www.hss.state.ak.us/dph/bvs/statistics
(907) 465-8604

REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 5. Mental Health
Chapter 6. Educational and Community-Based Programs

NOTES

AFTERWORD

THEMES

The stories presented in this volume are, first and foremost, Alaskan stories. Our history, our place and our people are at their heart. The Alaskans who tell the stories share the knowledge and experience of how they have wrestled with problems in their own Alaskan communities. Their intent is to help other Alaskans pursue healthier, happier, and safer lives.

This collection of stories is a strategic plan that emphasizes process. Strategic planning—like teaching and learning through stories—is an ongoing, dynamic and collaborative process. Both require the exchange of examples, ideas, perspectives, concerns, imagination and understanding. These stories are to be read, retold, examined and discussed to help others find or invent the solutions that work for them. This plan is an invitation to other communities and other Alaskans to share their stories, to join an Alaskan talking circle.

The stories in this volume were selected for diversity of issues and locations. They share many links to each other. Common themes include the importance of:

- Community
- Elders
- Traditional knowledge
- New knowledge
- Collaboration
- Leadership, and
- Local ownership of both the problems and solutions.

Alaska is a place of dramatic change. We see social, political, economic and cultural changes animating and complicating many of the issues that run through the stories.

In the paragraphs below we examine a few common threads: the nature of public health and of problem solving in Alaska; the varied contributions of children and adolescents; and the settings in which these stories might find a useful home.

Public Health

The problems and solutions explored in these stories are what we call “public health” issues. The United Nations World Health Organization defines *individual* health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” These stories suggest that Alaskan communities see *public* health in similarly broad terms. The health status of the community—however broadly or narrowly we choose to define community—is not just its collective physical health; it also embraces economic, environmental, social and spiritual dimensions of life.

Family Spirit Gathering is not just about child abuse and family placement. It is about how communities can reconnect with a meaningful past and mitigate the effects of social, cultural and physical trauma.

Difficult Decisions is not just about controlling the sale of alcohol in Barrow. It is an examination of the fundamental values of a growing multi-ethnic community, of its visions of the future and of how people go about caring for each other.

A Safe Harbor in Hard Times is not just about getting out of the rain when you've been down and out. It is about how important it is to health to be a member of a community and to be treated with dignity and respect, especially after the normal flow of a healthy life has been severely disrupted.

These are only a few examples of the important aspects of public health highlighted by stories in this volume.

Problem Solving

Public health problem solving requires collaboration. All parties to a problem must be involved to understand the issues and fashion a workable solution. Successful problem solving involves collaboration among local communities and, regional, tribal, state or federal agencies.

Successful solutions often come when "outside" agencies respond positively to community initiatives and when communities propose and participate in solutions that meet local conditions. Sometimes the initial impetus for solving a problem comes from outside the community, sometimes from within.

In *7 Generations* we saw villages frustrated and apathetic in the face of new problems rooted in new lifestyles and unfamiliar materials. The State of Alaska's emphasis on its enforcement authority failed to engage people in environmental health improvement. Providing technical assistance was a vital step in the right direction. Promoting local ownership and understanding of the problems and solutions led to establishment of successful collaboration between the State of Alaska and over 180 rural communities.

Family Spirit Gathering is a federally funded and state administered program. The program seeks to find culturally appropriate strategies for dealing with domestic violence and substance abuse that often lead to child placements outside the home. A Kongiganak elder redesigned the program to increase its chances for success. In Napakiak, we saw Yup'ik Elder Peter Jacob Sr. hug a Bethel based State social worker at their first Family Spirit Gathering. In doing so he bridged a bitter gulf created by past failures to collaborate. Through this simple and instructive gesture he made future cooperation in building a healthier community possible.

Successful public health problem solving requires collaboration among diverse people at the local level as well. These groups take on many different forms depending on the nature of the problem, the skills of the individuals and the type of community.

In *A Tradition of Learning* we see that all village factions had to agree to participate as a Policy Steering Committee for local substance abuse counseling to succeed. Whatever differences might have been, they were put aside for the common good.

In *Don't Give Up*, a spontaneous pedestrian bike path coalition turned around a construction project in a few weeks. The project was years in the making and nearly completed on the ground. The State road construction team demonstrated spontaneity as well by taking on the project at the last moment with no plans, formal budget or formal rights of way in hand. They completed the path a few days before the snows came.

In *Creating Healthy Communities*, Sitka human service agencies had to learn to collaborate in order to understand and effect health systems change. A successful collaborative grant writing committee spawned a steering committee for their Sitka Turning Point Towards Health Partnership. These successes in turn have led to a comfortable system of collaborative leadership that sustains cooperative efforts.

There are no one-size-fits-all solutions to public health problems in Alaska. Alaska's size, vast distances, climatic extremes, sparse infrastructure and local histories of boom, bust and trauma confound solutions designed for other places in the United States. Providing basic modern medical services is therefore always a creative challenge.

In *Community Health Aides* we see how Alaska invented a unique health care worker to provide health services in the villages. Community health aides are also culture brokers and linguists. Many are community members by birth. They fight epidemics and manage emergencies. They provide preventive and primary care services and enable visiting specialists do the most for the community under severely limiting conditions.

Helping Community Hospitals describes a federal program to stabilize and assist rural hospitals. The generally low census and remote location of many rural hospitals increase the cost of providing essential services. Some hospitals struggle with seasonal variations in workload when tourists, fish processors and fishing crews increase the population of small communities. The Rural Hospital Flexibility Program provides cost-based reimbursement rates for Critical Access Hospitals and provides technical assistance to small hospitals and clinics throughout the state.

Young People and the Future of Healthy Alaskan Communities

Many of our stories highlight the important roles that young people play in the health of our communities. The health, safety and happiness of our children are often key motivators for health improvements. But the young people also appear in our stories contributors to the public health. In the *Spirit of Youth* chapter, young people take on significant community health challenges. They perform extraordinary life saving deeds as Dragon Slayers in Aniak. They create a skateboard park in Homer and in doing so mastered many public processes and replaced the negative public image of "skateboard punks." In Anchorage, a high school student turns her sister's tragic death into an opportunity to teach other kids about the dangers of abusive relationship. Two sisters in high school invent an Ice Crawler robot to move across thin ice to people trapped in icy lakes.

In Kake, the high school Youth Court helps teens re-direct their lives in positive directions. In the Bristol Bay Area, teen volunteers work with the Helping Hands program to help elders at the end of life. They do chores and provide respite care. They assist elders in recording traditional knowledge and life experiences in journals. Their volunteer work allows elders to close their lives sharing and teaching and providing a legacy for family and community.

In the *Dumpster Art* story a class of Bethel sixth graders took on the health dangers of second hand smoke. They painted a bright red dumpster with a cigarette smoking skull at a key intersection so nobody could miss the message. They also created editorial cartoons, wrote letters to the editor, did radio advertisements, organized a parade, testified at City Council and Chamber of Commerce meetings, and even presented awards to smoke-free businesses. They led their community to pass the state's first ordinance to control dangerous second hand smoke in public places.

And let's not forget how important school children are in villages if you want action on an issue. Explain an issue to the forth grade class and the city council will be ready to take it up the following day ... just ask any water treatment plant operator in a village that has had a *7 Generations* class.

Settings for Using This Plan

Creating Healthy Communities: An Alaskan Talking Circle is about the processes involved in dealing with public health issues in Alaska. Public policy makers, lawmakers, administrators, program managers, researchers and planners should find these stories valuable in deepening their understanding of public health. Teachers may use these stories in high school, college and graduate school classes to give students a better general understanding of challenges in Alaskan communities. Similarly, these stories can focus discussion in human service council meetings, workshops and conferences, or in other less formal settings where a detailed, shared example can focus and stimulate discussion.

The sections that follow the story in each chapter suggest ways to further explore the issues. They are not meant to constrain discussion. Teachers and other users are urged broaden or sharpen their inquiry to meet their own needs and interests.

We hope that this adventure in using stories as the vehicle for public health strategic planning stimulates further interest in using stories to teach, plan and foster mutual understanding of the challenges facing Alaskans.

Conclusion

This collection of stories suggests that the solutions to our public health issues must be made not just for our community today, but for the future, for those who are not yet members of the community. Alaskans want a future that includes elders who pass along their knowledge in an environment that promotes health. We seek lifestyles in which violence is not a solution, alcohol abuse isn't a problem, and good habits and healthy choices for eating, drinking and exercising are the norm. We work for communities where health care services are accessible and where community members join together to help each other overcome difficulties and make a safe, happy and healthy life.

Public health efforts focus on assuring the conditions under which people can be healthy. There are many ways to promote health and prevent disease through organized, scientifically based, community efforts. This volume contains only a handful of stories about the public health challenges and about the creative solutions that work in Alaska. There are many more stories to be told about other strategies that work. We hope that Alaskans will find a way to collect and share these stories, to celebrate their achievements, and to spread their knowledge and experience.

CORE PRINCIPLES FOR HEALTHY ALASKANS 2010 STRATEGIC PLANNING

Adopted by the Healthy Alaskans Partnership Council March 2001

1. **Partnerships and collaborative efforts** including community groups and citizens, health care providers, and state and local officials are important and effective for implementing changes to improve public health at the community and at the state level.
2. **Broad community participation** ensures local ownership. The community guides the process—collective thinking ultimately results in more sustainable solutions to complex problems, and builds the experience for responding to emerging needs.
3. **Readily available data relevant to communities** (and instruction in data use) will support community involvement.
4. **“Best practices”** that are comprehensive, sustainable, and accountable should be identified wherever possible for the benefit of all communities, and all partners.
5. Build on existing **assets** and **relationships** to the extent possible—including **involving children and youth, elders**, and other specific groups likely to be affected by changes or by programs, or who have specific needs. Community engagement offers the best opportunity to strengthen protective factors and to reduce risk factors.
6. Strategies are needed for **underserved rural areas and populations**, especially addressing **health and public health workforce** in those locations, and ensuring equal access to health services for all (e.g. people with limited English proficiency, traditional belief systems).
7. Programs and activities should be **coordinated and linked** with parallel and mutually supportive prevention initiatives, planning, and research efforts in the Native health care system, and in other public and private domains (economic development, education, behavioral health, etc.).
8. **Systems analysis** and needs assessments at state and community levels, as well as research, will help ensure alignment of strategies with community needs, assets and desires. They also provide the basis for realistic implementation strategies. (Systems analysis means examination of inputs, processes and outputs or results, and includes the environmental conditions that affect how the system of interest works. A systems approach implies that one is aware of multiple relationships and factors that can affect outcome or output, as opposed to a single cause model, and it suggests that the components and their relationships to one another can be examined, and modified to effect a change in results.)
9. **Outcome measures and indicator tracking** will be critical tools for measuring progress, managing programs, and refining policies. Based on consensus indicators, data help show the public and policymakers both accomplishments and areas where existing programs are not accomplishing hoped-for goals.
10. Stable and adequate resources for the **public health infrastructure** are a good public investment. Public health infrastructure is defined in Healthy People 2010 as “the resources needed to deliver the essential public health services to every community—people who work in the field of public health, information and communication systems used to collect and disseminate accurate data, and public health organizations at the State and local levels in the front lines of public health.”

ABOUT HEALTHY ALASKANS 2010

(Adapted from the Introduction to Volume I)

Healthy Alaskans 2010 is a framework for realizing a vision: healthy Alaskans in healthy communities. It is a plan that includes a set of targets for 2010 that, if achieved, would reflect improved health status since 2000. A planning process involving participants from across the state has produced a set of goals, selected indicators, and targets for those indicators, published in December 2001 as *Volume I: Targets for Improved Health*. These provide a framework for action at the local and state level, and a way to address new problems with new measures.

Volume II: Creating Healthy Communities contains diverse examples of strategies that can help Alaska realize the targets identified in Volume I. The examples in this volume could be expanded upon in the future, if there is interest, and if resources can be found to continue the effort.

Volume III: References and Resources contains summaries of statewide health planning documents, cross-referencing materials, and an extensive list of acronyms and abbreviations that are used often, or at least occasionally, by people in public health.

All three volumes as well as additional resource material (as it is produced), such as the Alaska Health Profiles Online, are posted to the Alaska Division of Public Health website at www.hss.state.ak.us/dph/deu.

Healthy Alaskans 2010 emerged from the Alaska Public Health Improvement Process, funded in part by the Robert Wood Johnson Turning Point grants. It is a state-focused adaptation of the national planning process called *Healthy People 2010*, sponsored by the United States Department of Health and Human Services. Representatives from four “Turning Point” communities have been involved throughout the planning process.

The Alaska Public Health Improvement Process Steering Committee set ten goals (1999 Report) that have guided the Healthy Alaskans 2010 planning work:

1. Assure access to public health information for communities, policy makers, and the general public.
2. Assure a well-trained, competent public health workforce.
3. Develop a strong legal framework for Alaska’s public health system.
4. Assure accountability for the public’s health.
5. Assure sufficient, stable funding for public health action.
6. Assure effective communication capabilities in the public health system.
7. Increase public input in statewide policy decisions.
8. Engage communities to solve local health problems.
9. Increase personal responsibility for individual health.
10. Improve interagency communication, coordination, and collaboration among state public health, mental health, substance abuse and environmental health agencies.

In 2000, the Alaska Department of Health and Social Services acknowledged the contributions of the partnership that had worked so effectively to develop the vision and goals for the Alaska Public Health Improvement Process (APHIP). The Department asked the APHIP Steering Committee to become the Healthy Alaskans Partnership Council. One of the Council’s core principles is that broad community participation ensures local ownership. The community guides the process. Collective thinking ultimately results in more sustainable solutions to complex problems and builds the experience for responding to emerging needs. Collaboration and partnership with communities, Native health organizations, and health care workers are essential to mobilizing the state for achieving goals for longer and healthier lives.

Engaging people and their communities to improve health status means that all members of the community—individuals and organizations—are public health partners. Local governments in Alaska are not mandated to assume responsibilities for public health but may do so through local ordinance. At the present time (2002) only the North Slope Borough and the Municipality of Anchorage have health powers and offer services similar to city and county governments elsewhere. Regional Native health corporations, community health centers, hospitals, emergency medical personnel, as well as non-profit organizations and care providers all do health promotion and prevention work in addition to providing treatment services. As shown in the stories in this book, youth, elders, volunteers, community leaders, and state workers from many departments are all key partners for improving the health of the population.

HEALTHY ALASKANS PARTNERSHIP COUNCIL (2002)

During 2002, participants on the Healthy Alaskans Partnership Council included Laraine Derr, Paul Sherry, Brian Saylor, Delisa Culpepper, Carmen Rosa Mallipudi, Bill Allen, Mike Conway, Peter Nakamura, Cynthia Navarette, Carol Ballew, Karen Perdue, Ken Glifort, Tom Lefebvre, Susan Soule, Peter Wallis, Pam Watts, Anne Shultz, Karen Pearson, Janet Clarke, Walter Majoros, Merry Carleson, James Jordan, Kathy Craft, Jean Becker, Cecile Lardon, Cheryl Kilgore, Kay Klose, Rhonda Richtsmeier, Lisa Sadleir-Hart, Julia Smith, Cindy Baldwin-Kitka, Penny Lehman, Laura Wertz-Stein, Aurelia Hughes, Stan Steadman, Robert Ruffner, Joann Hagen, Bill Stokes, Senator Bettye Davis, and others, including other staff of the Division of Public Health and offices of the Department.

Other citizens have attended the Council's quarterly meetings, given ideas to staff at other conferences and meetings, and communicated by phone or email with ideas and comments.

In addition to advising the Department of Health and Social Services as it develops the state health planning materials, the Healthy Alaskans Partnership Council continues the oversight of the Alaska Public Health Improvement Process implementation grant from the Robert Wood Johnson Foundation. The focus of the implementation grant is the first goal listed above from the APHIP: *to assure access to public health information for communities, policy makers, and the general public*. Development of the Alaska Public Health Information System includes (a) making more data and publications easily accessible (primarily through website posting and cross-referencing, and also through developing new routine reports for publication), (b) posting regional health status profiles, and (c) developing online systems for requesting data through interactive queries of some of the key databases.

Healthy Alaskans 2010 Activities and Resources by Chapter

Healthy Alaskans 2010 Volume I Chapter	Healthy Alaskans 2010 Volume II Stories	National Healthy People 2010 Linked Chapters	Coalitions, Key Organizations & Partnerships (in addition to Division of Public Health, Alaska Department of Health & Social Services)	Selected Alaskan Planning Documents
HEALTH PROMOTION				
1. Physical Activity and Fitness	8. Don't Give Up - The Dillingham Pedestrian/Bike Path	22. Physical Activity and Fitness	Alaskans Promoting Physical Activity Alaska Association of Health Physical Education, Recreation, and Dance Alaska Recreation and Parks Association National Park Service Alaska Department of Transportation and Public Facilities Alaska Division of Parks and Outdoor Recreation	Alaska Adolescents Take Heart Alaska State of Alaska Diabetes Control Plan Eat Smart Plan
2. Nutrition and Overweight	8. Don't Give Up - The Dillingham Pedestrian/Bike Path	19. Nutrition and Overweight	Alaska Breastfeeding Coalition Alaska Cooperative Extension Service Alaska Dietetic Association Alaska Food Coalition Alaska School Districts Dietary Managers Association -Alaska Affiliate Food Bank of Alaska Head Start Program Alaska WIC program Eat Smart Coalition	Alaska Cancer Control Plan Take Heart Alaska Alaska Commission on Aging State Plan State of Alaska Diabetes Control Plan Eat Smart Plan Public Health Nursing Long Range Plan Alaska Native Statewide Health Plan Maternal, Child & Family Health 5 Year Plan
3. Tobacco Use	7 Dumpster Art 9. Creating Healthy Communities	27. Tobacco Use	Alaska Tobacco Control Alliance American Cancer Society American Heart Association American Lung Association Municipality of Anchorage	Alaska Tobacco Control Plan Cancer Prevention and Control Plan Take Heart Alaska State of Alaska Diabetes Control Plan Public Health Nursing Long Range Plan Maternal, Child & Family Health 5 Year Plan ANTHC Strategic Plan 2002-2005
4. Substance Abuse	1. Healing Our Community 2. A Tradition of Learning 4. Family Spirit Gathering 6. Difficult Decisions 9. Creating Healthy Communities - Turning Point	26. Substance Abuse	Advisory Board on Alcoholism and Drug Abuse Substance Abuse and Mental Health Services Administration (SAMHSA) Alaska Mental Health Trust Authority Alaska Comprehensive and Specialized Evaluation Services Alaska Department of Corrections Alaska Community Mental Health Services Association Alaska Rural Mental Health Providers Association Alaska Mental Health Association National Alliance for the Mentally Ill – Alaska Inhalant Abuse Steering Committee	Comprehensive Integrated Mental Health Plan Alaska Adolescents Cancer Prevention and Control Plan Health Plan for Alcohol and Drug Abuse Services Alaska Native Statewide Health Plan ANTHC Strategic Plan 2002-2005 Results Within Our Reach Maternal, Child & Family Health 5 Year Plan Alaska's Comprehensive FAS Project

Healthy Alaskans 2010 Activities and Resources by Chapter

Healthy Alaskans 2010 Volume I Chapter	Healthy Alaskans 2010 Volume II Stories	National Healthy People 2010 Linked Chapters	Coalitions, Key Organizations & Partnerships (in addition to Division of Public Health, Alaska Department of Health & Social Services)	Selected Alaskan Planning Documents
HEALTH PROMOTION (continued)				
5. Mental Health	<ul style="list-style-type: none"> 1. Healing Our Community 2. A Tradition of Learning 4. Family Spirit Gathering 9. Creating Healthy Communities 10. Strengthening Community Care 	18. Mental Health and Mental Disorders	<ul style="list-style-type: none"> The Alaska Mental Health Board The Alaska Mental Health Trust Authority Alaska Comprehensive and Specialized Evaluation Services The Alaska Department of Corrections Alaska Community Mental Health Services Association Alaska Rural Mental Health Providers Association Alaska Mental Health Association National Alliance for the Mentally Ill Substance Abuse and Mental Health Services Administration Alaska Psychiatric Institute 	<ul style="list-style-type: none"> Alaska Adolescents In Step: Comprehensive Mental Health Plan Invest in Our Children Strategic Plan Alaska Injury Prevention Plan Results Within Our Reach - A/D Plan A Shared Vision II Strategic Mental Health Plan Alaska Commission on Aging State Plan Alaska Native Statewide Health Plan Maternal, Child & Family Health 5 Year Plan Take Heart Alaska
6. Educational and Community-based Programs	<ul style="list-style-type: none"> 1. Healing Our Community 2. A Tradition of Learning 3. 7 Generations 4. Family Spirit Gathering 5. Easing the End of Life Journey 6. Difficult Decisions 7. Dumpster Art 9. Creating Healthy Communities 10. Strengthening Community Care 12. Community Health Aides 13. A Safe Harbor 	7. Educational and Community-based Programs	<ul style="list-style-type: none"> Alaska Primary Care Association Alaska Health Education Consortium CDC Planned Approach to Community Health programs (PATCH) CDC MAPP 	(all)
7. Health Communication	<ul style="list-style-type: none"> 2. A Tradition of Learning 4. Family Spirit Gathering 6. Difficult Decisions 7. Dumpster Art 8. Don't Give Up 9. Creating Healthy Communities 10. Strengthening Community Care 12. Community Health Aides 	11. Health Communication	<ul style="list-style-type: none"> Alaska Health Education Library Project (AHELP) Alaska Health Education Consortium (AHEC) Alaska Health Sciences Information Services (HSIS) Consortium Library, University of Alaska Anchorage Alaska Federal Health Care Access Network (AFHCAN) Alaska Primary Care Association, Alaska Telehealth Advisory Council Alaska Association of Public Libraries Health Alert Network 	(all)

Healthy Alaskans 2010 Activities and Resources by Chapter

Healthy Alaskans 2010 Volume I Chapter	Healthy Alaskans 2010 Volume II Stories	National Healthy People 2010 Linked Chapters	Coalitions, Key Organization & Partnerships (in addition to Division of Public Health, Alaska Department of Health & Social Services)	Selected Alaskan Planning Documents
HEALTH PROTECTION				
8. Injury Prevention	2. A Tradition of Learning 4. Family Spirit Gathering 6. Difficult Decisions 8. Don't Give Up 12. Community Health Aides	15. Injury and Violence Prevention	Injury Prevention Center SAFE KIDS Alaska Marine Safety Education Association Alaska Vocational Technical Center Department of Public Safety Alaska State Troopers State and Territorial Injury Prevention Directors Association	Alaska Adolescents Alaska Injury Prevention Plan AFHCAN Master Operating Plan Alaska EMS Goals Alaska Native Statewide Health Plan Alaska Trauma System Plan Results Within Our Reach Building Blocks Public Health Nursing Long Range Plan Maternal, Child & Family Health 5 Year Plan
9. Violence and Abuse Prevention	1. Healing Our Community 2. A Tradition of Learning 4. Family Spirit Gathering 6. Difficult Decisions 9. Creating Healthy Communities 10. Strengthening Community Care 12. Community Health Aides	15. Injury and Violence Prevention	Alaska Council on Domestic Violence and Sexual Assault Department of Public Safety Alaska Children's Trust Alaska Network on Domestic Violence and Sexual Assault Alaska Family Violence Prevention Project Adult Protective Services Department of Administration	A Shared Vision II Strategic Mental Health Plan Alaska Native Statewide Health Plan Alaska's Adolescents Results Within Our Reach Public Health Nursing Long Range Plan Building Blocks Maternal, Child & Family Health 5 Year Plan
10. Occupational Safety and Health		20. Occupational Safety and Health	Alaska Department of Labor and Workforce Development Alaska Department of Public Safety Federal Aviation Administration National Transportation Safety Board Alaska Federal Safety and Health Council Alaska Municipal League, Alaska Nurses Association Alaska Safety Advisory Council Highway Safety Planning Committee American Society of Safety Engineers American Industrial Hygienists Association Denali Safety Council National Safety Council US Department of Labor, NIOSH, Alaska Field Station, National Center for Injury Prevention and Control Veterans of Safety	Alaska Injury Prevention Plan

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HEALTH PROTECTION (continued)				
11. Environmental Health	3. 7 Generations 7. Dumpster Art	8. Environmental Health	Department of Environmental Conservation (DEC) Governor's Council on Rural Sanitation Alaska Division of Emergency Services Anchorage Water and Wastewater Utility U.S. Environmental Protection Agency U.S. Coast Guard U.S. Department of Interior	Akaska Native Tribal Health Consortium Strategic Plan Take Heart Alaska Public Health Nursing Long Range Plan
12. Food Safety	3. 7 Generations 10. Strengthening Community Care 12. Community Health Aides	10. Food Safety	Department of Environmental Conservation (DEC) Food and Drug Administration US Environmental Protection Agency US Department of Agriculture (USDA) Alaska Federation of Natives Alaska Community Action on Toxics - North Slope Borough Alaska Inter-Tribal Council University of Alaska Institute for Circumpolar Health Studies US Department of the Interior	Rural Sanitation 2005 Action Plan (Ask agencies for relevant codes)
13. Oral Health	9. Creating Healthy Communities	21. Oral Health	Department of Environmental Conservation Division of Medical Assistance - Medicaid Alaska Native Tribal Health Consortium	Alaska Native Statewide Health Plan Rural Sanitation 2005 Action Plan Maternal, Child & Family Health 5 Year Plan
14. Vision and Hearing	2. A Tradition of Learning	28. Vision and Hearing	Early Hearing Detection and Intervention Program Deaf Community Services National Center for Hearing Assessment and Management National Institute on Deafness and Communication Disorders NIOSH Work Related Hearing Loss Site Alaska Division of Vocational Rehabilitation Assisstive Technology Library of Alaska Alaska Talking Book Center National Eye Institute Healthy Vision Consortium American Optometric Association	Maternal, Child & Family Health 5 Year Plan State Health Plan for Alaska (1984)

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PREVENTIVE SERVICES AND ACCESS TO CARE				
15. Access to Quality Health Care	2. A Tradition of Learning 5. Easing the End of Life Journey 9. Creating Healthy Communities 10. Strengthening Community Care 11. Helping Community Hospitals 12. Community Health Aides 13. A Safe Harbor	1. Access to Quality Health Services	Alaska Federal Health Care Access Network (AFHCAN) Alaska Telehealth Advisory Commission Department of Administration, Assisted Living Quality Coalition Alaska Human Resource Investment Council (AHRIC) University of Alaska Statewide Vocational/Technical Education Advisory (UASVTEAC) Long-Term Care Implementation Team, Bureau of Primary Health Care (BPHC) National Health Service Corp (NHSC) U.S. Department of Health and Human Services Alaska Primary Care Association Denali Commission, Alaska Center for Rural Health	Alaska Native Tribal Health Consortium Strategic Plan Cancer Prevention and Control Plan Alaska Trauma Control Plan Invest in Our Children Strategic Plan Alaska EMS Goals, Rural Health Plan Alaska Commission on Aging State Plan Alaska Native Statewide Health Plan State Plan for Independent Living Statewide EMS Communication Plan Building Blocks - Health Facilities Plan Public Health Nursing Long Range Plan Public Health and Hospital Preparedness and Response Program Alaska's Comprehensive FAS Project
16. Maternal, Infant, and Child Health	9. Creating Healthy Communities 11. Helping Community Hospitals 14. Spirit of Youth	16. Maternal, Infant and Child Health	Association of Alaska School Boards American Academy of Pediatrics Alaska Breastfeeding Coalition National SIDS Resource Center National Maternal and Child Health Clearinghouse Injury Prevention Center SAFE KIDS	Maternal, Child & Family Health 5 Year Plan In-Step A Shared Vision II Building Blocks Alaska Native Statewide Health Plan Alaska's Adolescents Results Within Our Reach Alaska Native Tribal Health Consortium Strategic Plan Year 2000 Childhood Immunization Initiative Public Health Nursing Long Range Plan Tuberculosis Control In Alaska Alaska's Comprehensive FAS Project
17. Family Planning	9. Creating Healthy Communities	9. Family Planning	Association of Alaska School Boards Planned Parenthood	Alaska Adolescents Invest in our Children Building Blocks Maternal, Child & Family Health 5 Year Plan Alaska's Comprehensive FAS Project
18. Immunizations and Infectious Diseases	7. Dumpster Art 12. Community Health Aides	14. Immunizations and Infectious Diseases	CDC's Arctic Investigations Program Department of Corrections Anchorage Department of Health and Human Services	Year 2000 Childhood Immunization Initiative Public Health and Hospital Preparedness and Response Program Tuberculosis Control In Alaska Public Health Nursing Long Range Plan

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PREVENTIVE SERVICES AND ACCESS TO CARE (continued)				
19. Sexually Transmitted Diseases and HIV Infection		13. HIV Infection 25. Sexually Transmitted Diseases	Municipality of Anchorage Department of Health and Human Services Alaskan AIDS Assistance Association Anchorage/Statewide HIV Care Consortium Interior AIDS Association, Interior HIV Care Consortium Alaska HIV Prevention Planning Group Department of Corrections Alaska AIDS Drug Assistance Program	The 2001-2003 HIV Prevention Plan Public Health Nursing Long Range Plan Alaska Native Statewide Health Plan Results Within Our Reach
20. Arthritis and Osteoporosis	8. Don't Give Up 5. Easing the End of Life Journey	2. Arthritis, Osteoporosis, and Chronic Back Conditions	Access Alaska Alaska AARP Alaska Commission on Aging Arthritis Foundation -Washington/ Alaska Chapter Alaska Chapter of the Lupus Foundation of America Pediatric Sub-Specialty Clinic, Children's Hospital at Providence	Arthritis Prevention Plan Eat Smart Plan
21. Heart Disease and Stroke	8. Don't Give Up 5. Easing the End of Life Journey	12. Heart Disease and Stroke	American Heart Association Alaska Affiliate Eat Smart Alaska! Take Heart Alaska Coalition American Red Cross Alaska Emergency Medical Services System Alaska Tobacco Control Alliance State Diabetes Coalition	Take Heart Alaska Eat Smart Plan
22. Cancer	5. Easing the End of Life Journey	3. Cancer	American Cancer Society Pacific Northwest Division Alaska Affiliate Alaska Dental Association	Cancer Prevention and Control Plan Alaska Tobacco Control Plan ANTHC Strategic Plan 2002-2005 Eat Smart Plan Maternal, Child & Family Health 5 Year Plan

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PREVENTIVE SERVICES AND ACCESS TO CARE (continued)				
23. Diabetes	8. Don't Give Up 5. Easing the End of Life Journey 12. Community Health Aides	5. Diabetes	Alaska Diabetes Coalition, Alaska Area Diabetes Model Program, Alaska Association of Diabetes Educators, American Diabetes Association, Alaska Dietetic Association, Alaska Nurse Practitioners Association, Alaska Academy of Physician's Assistants, Eat Smart Alaska, Veterans Administration Diabetes Program, Providence Alaska Diabetes Program, Juneau Community Diabetes Coalition, Fairbanks Patient Educators, Diabetes 2000 project of the American Academy of Ophthalmology	Diabetes Prevention and Control Plan Take Heart Alaska Eat Smart Plan
24. Respiratory Diseases	8. Don't Give Up 5. Easing the End of Life Journey	24. Respiratory Diseases	Arctic Investigations Unit National Heart, Lung, and Blood Institute American Lung Association National Lung Health Education Program	Alaska Tobacco Control Plan - Alaska Native Statewide Health Plan - Disabilities and Special Education - State Health Plan for Alaska - Tuberculosis Control for Alaska
25. Disability and Secondary Conditions	8. Don't Give Up 5. Easing the End of Life Journey	6. Disability and Secondary Conditions	Alaska Division of Vocational Rehabilitation Assistive Technology Library of Alaska Disability Rights and Education Defense Fund Assistive Technologies of Alaska	State Plan for Independent Living State Health Plan for Alaska (1984)
PUBLIC HEALTH INFRASTRUCTURE				
26. Public Health Infrastructure	2. A Tradition of Learning 3. 7 Generations 4. Family Spirit Gathering 5. Easing the End of Life Journey 9. Creating Healthy Communities 10. Strengthening Community Care 12. Community Health Aides 13. A Safe Harbor	23. Public Health Infrastructure		A Shared Vision II - Alaska Emergency Operations Plan - Alaska EMS Goals - Alaska Injury Prevention Plan - Alaska Native Statewide Health Plan - Alaska Public Health Improvement Plan - Alaska Rural Health Plan - AFCHAN Master Operating Plan - Alaska Trauma Systems Plan - Alaska Native Tribal Health Consortium Strategic Plan - Children's Health Strategic Plan - Rural Sanitation 2005 Action Plan - State of Alaska Emergency Operations Plan - State Plan for Independent Living - Statewide EMS Communications Plan - Health Facilities Plan - Public Health & Hospital Preparedness Plan - Public Health Long Range Nursing Plan - State Health Plan for Alaska -Maternal, Child & Family Health - Public Health and Hospital Preparedness and Response Program